MEDICAL ACTION PLAN

This document should be displayed prominently

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Updated:

Patient Information

Name: _____ DOB: _____

Phone # _____

Allergies: _____

_____

Other Health Issues: _____

_____

_____

_____

Emergency Contacts

Primary: _____ Cell Phone # _____

Alternate # _____

Secondary: _____ Cell Phone # _____

Alternate #

Physician: _____ Phone # _____

Address: _____

Closest hospital or urgent care: _____

Address: _____

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HEALTH ISSUE: _____

SIGNS AND SYMPTOMS BY SEVERITY

Self Care/Monitor (mild)	Contact Doctor (moderate)	Call 911 (severe)

Self Care Steps: _____

HEALTH ISSUE: _____

SIGNS AND SYMPTOMS BY SEVERITY

Self Care/Monitor (mild)	Contact Doctor (moderate)	Call 911 (severe)

Self Care Steps: _____