Cherokee County School District

HEMOPHILIA ACTION PLAN

STUDENT:_____ D.O.B._____

SCHOOL: _____ GRADE:_____ TEACHER:_____

PARENT/LEGAL GUARDIAN:_____

PHONE #s: HOME:_____ WORK: _____

CELL: _____

Specific Instructions:

_____

_____

_____

_____

_____

_____

_____

_____

Approve participation in the following activities by placing a check mark in the box:

- ☐ Tetherball
- ☐ Touch Football
- ☐ Floor Hockey
- ☐ Kickball
- ☐ Softball
- ☐ Volleyball
- ☐ Soccer
- ☐ Dodgeball
- ☐ Basketball

I, _____ ,authorize the physician's office to release confidential information about my child.

Parent / Legal Guardian's Signature Date

Physician's Signature Date

Physician's Printed Name Physician's Phone Number