Student Health Services

Individual Health Care Plan

Student Name: ________________________________ **Date of Birth:** ________________

Teacher: ________________________ **Grade:** ____________ **School:** _______________

Parent/Guardian Information:

Mother's Name: ______________________
Home #: ____________________________
Work #: ____________________________
Mobile/Other: _______________________
Address: ___________________________
Email: _____________________________

Father's Name: ______________________
Home#: ____________________________
Work #: ____________________________
Mobile/Other: _______________________
Address: ___________________________
Email: _____________________________

Note: This student has a health condition of which the school system staff needs to be aware. The medical diagnosis, care during school hours, emergency care, and individual considerations are stated below:

Medical Diagnosis/Condition:

____
____
____
____

Action Plan for School:

____
____
____
____
____

Medications (Dosage/Frequency):

____
____
____

Individual Considerations:

____
____
____
____

I am the parent/guardian of __________________________________ and request that the Individual Health Care Plan be utilized during school hours.

School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this Individual Health Care Plan authorizes Student Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Health Care Provider Signature: ____________________ **Date:** ______________

Physician name (print)/phone number: ____

Parent Signature: ______________________________________ **Date:** ______________

07-08