**Health Care Plan**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **Health Concerns/Diagnosis:** |

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| **Allergies:**  |
| **Medications:**  |
| **Activity Restrictions:**  |
| **Dietary Concerns/Restrictions:**  |
| **Health Action Plan****CALL 911 FOR**  |
| **Health Care Provider:** **Phone No:** |
| **Contact Information:** |
| **Parent/Guardian:****Phone No:**  |
| **Home oHHAddress:**  | **Teacher**:  |
| **Health Assistant:**  | **Phone:**  |
| **District Nurse:**  | **Phone:**  |

**\*This in no way replaces a physician order for prescribed services and is for informational purposes only.**

Health Assistant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RN Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­ Date: