**Health Care Plan**

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

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

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

|  |  |
| --- | --- |
| **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: