Dunlap Community Unit School District #323

Dates Updated:

INDIVIDUAL HEALTH CARE PLAN

Student Name: ______________________ Date of Birth: __________ School Year: __________

Teacher: ______________________ Attending School: ______________________

Grade: __________ DOR: Dunlap Unit SD 323

Contact Information (see attached **Emergency Information Sheet**):

Physician Treating Medical Condition: ______________________ Ph#: __________ FAX#: __________

Hospital Choice (please check one): ☐ OSF St. Francis ☐ UnityPoint Health - Methodist ☐ Proctor Hospital ☐ Pekin Hospital

Health Information to Teachers:

has a health condition of which you as his/her teacher need to be aware. The description of this condition, as well as emergency care and individual considerations, are stated below:

Medical Diagnosis/Condition:

Medications Required for Diagnosis (a medication authorization form must be completed for in-school medications):

Drug Name: ______________________ Dose: __________ Time Given: __________

Drug Name: ______________________ Dose: __________ Time Given: __________

Drug Name: Dose: Time Given:

Action Plan:

Individual Considerations:

Field Trips: Teacher will take **Individual Health Care Plan** and any equipment/medication needed on field trips along with the student's **Emergency Information Sheet.** Teacher will be instructed on the correct use and procedure for equipment and medications.

1. As parent/guardian of I give permission for this plan to be available for use in my child's school, and for the school nurse to contact the above named physician by phone, fax, or in writing when necessary to complete this plan.
2. It is understood by parents and physician that this plan may be carried out by school personnel other than the school nurse. The school's registered nurse is responsible for the delegation of this plan to unlicensed school personnel when appropriate.
3. This plan will be reviewed annually and/or whenever the health status or medications change and **it is the responsibility of the parent to notify school nurse of these changes.**

Physician Signature ______________________ Date: __________

Parent/Guardian Signature ______________________ Date: __________

School Nurse Signature ______________________ Date: __________

Homeroom Teacher Signature ______________________ Date: __________

School Staff Signatures ______________________ ______________________

School Staff Signatures ______________________ ______________________