SAN ANGELO INDEPENDENT SCHOOL DISTRICT

INDIVIDUALIZED MEDICAL PLAN

CURRENT HEALTH STATUS OF STUDENT WITH SPECIAL HEALTH PROBLEM(S)

Student's Name _____ Sex _____ Birth date _____

Parent/Guardian Name _____Daytime phone_____

Grade _____ School Year _____

Student's Primary Diagnosis or Presenting Problem:

Physician_____Phone_____Address_____

May the school nurse contact the physician in case there are questions or concerns in making a care plan for your child?

Yes _____ No _____

Does you child have allergies? Yes _____ No _____ If yes, what is she or he allergic to? _____

Is your child prone to getting any particular health problems on a regular basis? Yes _____ No _____

Is there a special way your child behaves when he/she is ill or about to become ill? Yes _____ No _____

Special Instructions: Please note any special instructions the school nurse needs to know about your child. Also list any care instructions needed for school care.

Primary Care Physician_____Phone_____Address_____

Please list all medications that your child is currently taking and the physician prescribing each one

Medication	How Often	Health Problems	Physician
1.			
2.			
3.			
4.			
5.			

Please list specialists, clinics, therapists, or other physicians consulted for your child, the problems involved, and the dates of the most recent exam.

MD or other specialist	Problem	Date last visited
1.		
2.		
3.		
4.		
5.		

May the school nurse contact any of the above listed health professionals in the event of a concern or question? Yes _____ No _____

Comments:

_____ _____

Parent's/Guardian/s Signature **Date**

_____ _____

Physician's Signature **Date**

I also give the school nurse permission to share this information with appropriate school personnel.

_____ _____

Parent/Guardian Signature Date

Revised (11/2012)