

CHA INDIVIDUAL HEALTH PLAN

Student Name: _____ DOB: _____

Teacher: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

TO BE COMPLETED BY LICENSED HEALTHCARE PROFESSIONAL

DIAGNOSIS: _____

Accommodations while at the school: _____

Medication to be administered*: Yes No

If yes, list medication, administration details, potential side effects: _____

*For complete medication administration information, it will be necessary for the medical provider and parent/guardian to complete the Administration of Medicine form.

Suggested classroom strategies to support this child's needs: _____

Potential consequences to child if treatment is not administered: _____

If applicable, staff will:

Complete a training specific to (diagnosis): _____

Be able to recognize: _____

Notify the parent/guardian if any of the following conditions exist: _____

To ensure the safety of your child we cannot delete a health care diagnosis which has previously been documented unless we have a signed note from the child's physician stating that the condition no longer exists; nor can we add an item(s) or change a medication without a signed note from the child's physician. I understand that Chestnut Hill Academy requires the most up-to-date information regarding my child's health. I also understand that for the safety of my child, my child's photograph and health information will be posted in the classrooms and kitchen.

Parent/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Administrative Signature: _____ Date: _____

This plan must be updated annually or whenever there is any change in treatment or the child's condition changes