District ONE91
Future Ready. Community Strong.

HEALTH PLAN

STUDENT________________________________ **DOB** __________ **DATE** __________

DIAGNOSIS/CONDITION:

____

Person to Contact	*Relationship*	*Work Phone*	*Home Phone*	*Cell Phone*
______________________	__________	___________	___________	__________
______________________	__________	___________	___________	__________

HISTORY:____

____

____

MEDICATIONS **SCHOOL** **HOME**

(✓ below if experienced by your child)

			School	Home
Name ______________________	Dose __________	Time ______	_________	________
Name ______________________	Dose __________	Time ______	_________	________
Name ______________________	Dose __________	Time ______	_________	________

ALLERGIES ____

____

TYPES OF LIMITATIONS/MODIFICATIONS

- Physical Education Yes ____ No ____ N/A ____
- Ambulation Yes ____ No ____ N/A ____
- Playground equipment Yes ____ No ____ N/A ____
- Swimming Yes ____ No ____ N/A ____
- Machinery operation Yes ____ No ____ N/A ____
- Diet Yes ____ No ____ N/A ____
- Other (please describe) ____

Please specify type of limitation/modification ________________________________

____

FIELD TRIP PLAN ____

____

____

EMERGENCY PLAN OF CARE

SIGNS OF EMERGENCY ____

____

____

EMERGENCY PLAN OF ACTION ____

____

____

____

Notify office when 911 is called

Health Care Provider ____________________ Clinic ____________________ Phone ____________

Hospital of Choice ____

NURSING DIAGNOSIS	**GOALS**
1. ____________________	____________________
2. ____________________	____________________
3. ____________________	____________________

	Plan Initiated	***Plan Reviewed/ Updated***
Parent/Guardian(s) Signature ____________________	Date ________	Date ________
School Nurse ____________________	Date ________	Date ________
Health Assistant ____________________	Date ________	Date ________

Please contact the Licensed School Nurse if you have questions regarding this health plan or if you would like to meet to discuss other accommodations that may be needed.

***Co-curricular and Extra-curricular Activities**: If your child is involved in co-curricular / extra-curricular or other school sponsored activities or programs that take place during or outside of the school day, please contact the program coordinator, teacher or coach to discuss accommodations that may be needed as it relates to your child's medical condition. Please provide needed emergency medications directly to the program coordinator, teacher or coach.

I give permission for the Licensed School Nurse to consult (both verbally and in writing) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the medical condition and/or medication(s)/treatment(s)/procedure(s) being used to treat the condition.

LSN signature______________________________ Date copy sent to Parent____________