INDIVIDUALIZED HEALTH CARE PLAN
SCHOOL HEALTH MANAGEMENT PLAN

Student's Name: _____ Date of Birth: _____ School Year: _____

School: _____ Grade: _____ Classroom Teacher: _____

EMERGENCY CONTACTS:	Relationship:	Home phone:	Work phone:	Cell phone:
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____
3._____	_____	_____	_____	_____
PHYSICIAN:	CLINIC:		PHONE:	
_____	_____		_____	
HOSPITAL:			PHONE:	

Medical condition(s):

_____
_____
_____
_____
_____

Usual symptoms:

_____
_____
_____

Frequency of symptoms:

_____
_____
_____

Limitations:

_____
_____
_____

Additional information/Comments:

_____

_____

_____

SCHOOL PLAN OF ACTION

(Please list steps to manage medical condition at school)

1._____

2._____

3._____

4._____

5._____

Medications to be given to manage condition at school:

Medication:	Dose:	Route:	Time/Frequency:

Parent/Guardian Signature: Date:

_____ _____

This information will be available to appropriately designated school staff.