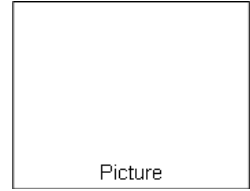




Eagle County School District Individualized Health Plan



Student	_____	DOB	_____	Home Phone	_____
Mother	_____	Work Phone	_____	Cell Phone	_____
Father	_____	Work Phone	_____	Cell Phone	_____
Guardian	_____		Phone	_____	
School Nurse	_____		Phone	_____	
School	_____	Grade	_____	Teacher	_____
Primary Physician	_____		Phone	Fax	_____
Specialist	_____		Phone	504 Plan/IEP	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital of Choice	_____		Allergies	_____	

Medical Diagnosis: _____

Medical History: _____

Medications taken at home: _____

Medications at school: _____

Health Concern 1: _____

Action: _____

Health Concern 2: _____

Action: _____

Health Concern 3: _____

Action: _____

As parent/guardian of the student, I give permission for school personnel to share this information, follow this plan, care for my child, and, if necessary, contact our physician. I assume full responsibility for providing the school with any prescribed medication and equipment devices. I approve this individualized healthcare plan for my child.

Parent Signature: _____ Date: _____

Nurse Signature: _____ Date: _____