Eagle County School District
Individualized Health Plan

Picture

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	☐ Yes ☐ No
Hospital of Choice			Allergies		

Medical Diagnosis: _____

Medical History: _____

_____

Medications taken at home: _____

Medications at school: _____

Health Concern I: _____

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: _____