



## Health Care Plan – Declination

Student's Name:

Date of Birth:

Medical Condition:

I, \_\_\_\_\_, acknowledge that I have been contacted by the health office staff at my child's school concerning my child's health status and at this time DO NOT believe a Health Care Plan is necessary to have on file at school.

**I acknowledge it is my responsibility to reach back out to the health office and school should this status change at any point.**

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Check here if completed over the phone with parent*

*Name of person who spoke with parent on the phone:* \_\_\_\_\_

*Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

**School HA/Nurse Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_