Individualized Health Plan Information

School:

Year:

Name:

Address:

Grade: **Date of Birth:**

Emergency Contacts (in order of priority)

1	**Phone #**	**Relationship**
2	**Phone #**	**Relationship**
3	**Phone #**	**Relationship**

Special Needs:

◯ **Asthma** ◯ **Seizures** ◯ **Cardiac** ◯ **Diabetes** ◯ **ADD/ADHD**

◯ **Food Allergy** ◯ **Emotional** ◯ **Bee Sting Allergy** ◯ **Other** _____

This child's condition may result in an Emergency (if "yes" activate 911)

◯ **Yes** ◯ **No**

Please check hospital of choice:

◯ **St. Joseph Regional Medical Center** ◯ **Memorial** ◯ **Other** _____

Does the above condition interfere with the child's learning process? ◯ **Yes** ◯ **No**