



BONNIE CONE CLASSICAL ACADEMY

Individualized Health Care Plan

Campus _____ School Year 20____/20____

Active 504 or IEP on file: Yes No If Yes, a 504 Coordinator needs to be present.

If no, is an IEP or 504 meeting required? Yes No

Does the student ride the bus? Yes No

If Yes, has transportation been notified: Yes No

Copy of plan distributed to teachers: Yes No

Name of Student _____

Age _____ DOB _____ Grade _____ Date _____

Parents: _____

Phone #s: Home: _____ Work: _____ Cell: _____

Email: _____

In case parents cannot be reached, call _____

at _____. Relationship to student: _____

Medical Provider: _____

Phone: _____ Address: _____

Medical Diagnosis: _____

Medical Instructions/ New Medications or Medication Changes: _____

Overall Assessment Data (General assessment of student entering at this time):

Excited Happy Neutral Anxious Scared Sad Other: _____

Conditions Needing Vigilance at School:

Medication: _____ Treatment: _____

Wound Care: _____ Other: _____



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What the Parents Will Do:

- Communicate with Teacher and Health Aide
- Bring in supplies as needed
- Call Attendance stating: Home for Chronic Illness or what the child's symptoms were
- Other: _____

What the School/Health Staff Will Do:

- Communicate with Parents and Teachers
- Allow rest, time in Health Office, parameters: _____
- Treat student per plan
- Other: _____

What the Student Will Do:

- Communicate with Teacher, Health Aide and Parents
- Other: _____
- Other: _____
- Other: _____

Additional Information (See Assistant Director for Academic Needs):

- Need schedule changes
- Go to half days
- Help with school work/ Teacher Intervention
- Other: _____

Parent Signature: _____ Health Staff Signature: _____

Assistant Director: _____ Other: _____

Approved by: _____

Health Program Representative