Lewistown Public Schools
School Year _____

General Health Care Plan

To be completed by a Healthcare Provider

Student Name: _____ DOB: _____ Age: _____

School: _____ Grade: _____ Teacher: _____

_____ Describe Health Concern/Diagnosis: (Please give a brief medical history if relevant.)
Allergies:
Medications: (Please note if medication is taken at home or at school) 1. 2. 3.
Dietary concerns or restrictions:
Transportation issues:
Comments/Special instructions:

Emotional/Behavioral concerns:

Student Specific emergency procedure

If you see this….	Do this….
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Contact Information

Parent/Guardian name: _____

Contact phone number(s): _____

Other emergency contact information will be taken from Infinite Campus.

Health Care Provider name: _____

Health Care Provider contact number(s): _____

Specialist(s): _____

Parent/Guardian signature:_____Date: _____

Health Care Provider signature: _____Date: _____