Cherokee County School District

SPECIFIC HEALTH NEED ACTION PLAN

STUDENT_____D.O.B:_____

HEALTH NEED _____

SHORT TERM NEED ☐ LONG TERM NEED ☐

TIME FRAME FOR SPECIAL INSTRUCTIONS _____

SCHOOL_____

TEACHER_____ GRADE_____

MOTHER / LEGAL GUADRIAN _____

PHONE _____

FATHER / LEGAL GUARDIAN _____

PHONE _____

Specific Instructions: _____

_____

_____

_____

(Parent will provide supplies/equipment.)

Is student released by the physician to return to school? Yes ☐ No ☐

I, _____, authorize the physician's office to release confidential information about my child.

_____ _____

Parent / Legal Guardian's Signature Date

_____ _____

Physician's Signature Date

_____ _____

Physician's Printed Name Physician's Phone Number