Student Services

Health Care Action Plan—Basic

Please return form to: _____ School _____ Fax

Name: _____ DOB: _____

ID#: _____ Grade: _____ Parent/Guardian: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: (mother) _____ (father) _____

Emergency Contact: _____ Phone : _____

Primary Care Provider: _____ Phone: _____

Specialist: _____ Phone: _____

Brief Description of Illness or Condition

Medications/Dose/Time

Physical Restrictions

Concerns/Urgent Action(s)

Comments

I give permission for the information contained on this HCAP to be shared with adults in the school setting that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one year or until the health status or physician's orders change. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care.

School Nurse Date | Parent/Guardian Date | Health Care Provider Date

Rev. 9/29/11