LA PRYOR INDEPENDENT SCHOOL DISTRICT
INDIVIDUALIZED HEALTH CARE PLAN
FOR SPECIAL HEALTH/DIETARY NEEDS

Child's Name_______________________________________DOB:___________________________

School: La Pryor Elementary School Year:_____________Grade:___________Date:____________

Parent(s)/Guardian(s):_____________________________________Home Number:_______________

Emergency Contact:_______________________________________Contact Number:______________

A. The Health Care Provider (may include physician, registered dietitian or other authorized medical professional) must provide:
   1. A detailed description of any special health concern related to your child, any special dietary supplements your child may need, including any special instructions related to his/her condition.
   2. Any allergies your child may have, symptoms of a reaction and action taken.
B. An updated Individualized Health Care Plan is required for each school year.
C. Special health/dietary needs will not be provided until the IHCP is completed and returned to the Health Clinic.
D. La Pryor ISD will provide special dietary needs at no charge to you. Training and instructions for all staff involved with your child will be conducted on special or emergency care your child may need.
E. A release from the Health Care Provider is required to discontinue any special needs ordered.
F. If life-threatening symptoms occur, staff will make a call to 911, even if the parent(s), guardian(s), or emergency contact cannot be reached.

I will communicate any changes in my child's condition or treatment. I understand and agree to comply with the above terms and conditions.

Parent/Guardian Signature:___________________________________Date:_____________________

***************************TO BE FILLED OUT BY THE HEALTH CARE PROVIDER***************************

List any special medical condition, including allergies, intolerance, dietary supplements, asthma, seizures, etc.:

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List any special equipment needed:____
Special Instructions/Restrictions/Precautions:_______________________________________

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List any special procedure that needs to be performed during school hours and how often:____________

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Allergic reactions child may experience with food or medications:______________________

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List any food substitutions or meal plan, prescribed by the Health Care Provider, or Dietician including milk, supplements/dietary supplements and meal preparation:_____________________________

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List any prescribed medications/treatments:____

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Call parents and 911 when the following symptoms occur:______________________________

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Health Care Provider Name:____
Provider Address & Phone#:____

Health Care Provider Signature:_________________________________Date:______________