Laurel Public Schools

Individualized Health Care Plan

Student: ______________________________ DOB: ___________________________ School Year: ________

Grade: __________________ School: ______________________________Teacher:____________________

Emergency Contact:____Phone:______________________

Healthcare Provider:____Phone:______________________

Diagnosis:____

____

Symptoms:____

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Restrictions:____

____

Treatment:____

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Additional Instructions:____

____

Parent Name: ____ Phone: _________________

Parent Signature: ____Date: _______________________________

Physician Signature: ____Date: __________________________