MIDDLEBOROUGH PUBLIC SCHOOLS
INDIVIDUAL HEALTH CARE PLAN

Name:	Date:	Photo
Birth Date:		
School:	Grade:	
Teacher:		
Health Concerns / Diagnosis and date:		

Allergies:	
Medications:	Dose / Time:
Emotional / Behavioral Concerns:	
Dietary concerns / restrictions:	
Health Care Plan:	

Parent Signature:*	Date:
M.D. Signature:	Date:
*Signature required	

Contact Information		
Parent / Guardian:	Home Phone:	
1.	Work:	Cell:
2.	Work:	Cell:

Home Address:

Emergency Contact:	Phone:
Primary Care Physician:	Phone:
Specialty MD:	Phone:
School Nurse:	Phone: