District Health Services

Individual Health Care Plan

Student Name: _____ **Date of Birth:** _____

Teacher: _____ **Grade:**_____**School:** _____

Note: This student has a health condition of which the school system staff needs to be aware. The medical diagnosis, care during school hours, emergency care, and individual considerations are stated below:

Medical Diagnosis/Condition: _____

_____

_____

_____

Action Plan for School: _____

_____

_____

_____

_____

Medications (Dosage/Frequency): _____

_____

_____

_____

Individual Considerations: _____

_____

_____

_____

_____

I am the parent/guardian of _____ and request that the Individual Health Care Plan be utilized during school hours.

School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this Individual Health Care Plan authorizes District Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Health Care Provider Signature _____ Date: _____

Physician Name (print) _____ Phone # _____

Physician Address _____ Fax _____

Parent Signature _____ Date: _____

Parent Name (Print) _____Phone # _____

Received by _____Date:_____

Date Reviewed by Cluster Nurse/Special Education Nurse: _____

Cluster Nurse/Special Education Nurse Signature: _____