



# Student Health Services

## Individual Health Care Plan

Where Students Come First

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 Student 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: \_\_\_\_\_