

# INDIVIDUALIZED HEALTH CARE PLAN

Livonia Public Schools

Confidential

Name:	
Health Concern:	
Date of Birth:	Student ID:
Case Manager:	Ext:

<p>Click Here to Add Picture</p>
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The following individuals have reviewed this Health Care Plan and support its implementation.

Parent / Guardian Signature	Date	Administrator Signature	Date	Doctor Signature (required)	Date
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