INDIVIDUALIZED HEALTH CARE PLAN

SCHOOL YEAR_____________ CAMPUS______________

NAME: DOB: Regular IHCP ❑ 504 IHCP ❑

HEALTH CONCERN(S)/ DIAGNOSIS:

Health Action Plan:

FOOD OR DRUG ALLERGIES:

DIETARY CONCERNS/RESTRICTIONS:

EMOTIONAL/ BEHAVIORAL CONCERNS:

Medications:	Dose/Time:

Parent Signature:	**Date**:
M.D. Signature (**or Med. Authorization form**): **Physician Name** (**PRINTED**):	**Date**:

CONTACT INFORMATION

Parent/Guardian:	Home phone:
1.________________________	Work:____________________ Cell:_____________________
2.________________________	Work:____________________ Cell:_______________________

Emergency Contact:	**Teacher**:
Emergency Contact:	**Phone:**

Copies: □ Parent □ Teacher ___________________ □ PE □ Library □ Music □ Transportation □ Nurse □ Cafeteria

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REV 06/16