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CONFIDENTIAL

INDIVIDUAL HEALTH CARE PLAN

If your child has a health condition you would like us to know more about, please fill out the following information so we can better care for your child if they have needs during the school day. Some examples include asthma, allergies, epilepsy, anxiety (including testing anxiety), diabetes, migraines, seizures, previous medical conditions that may reoccur, etc.

If your child has a chronic condition that requires ongoing care and/or medication (Allergies requiring an Epi-Pen, Asthma, Diabetes, or Seizure Disorder) please have your child's physician fill out an Action Plan specific to your child and their condition in addition to this form

Student Name: _____ Date: _____

Homeroom Teacher/Grade: _____

Health Information for Clinic Nurse:

Medical Diagnosis or Condition (Current or Previous):

Does your child take medicine for this condition? If so, what medicine(s) and in what order?

Are there things that aggravate your child's condition? _____

Are there non-medicinal strategies that help with your child's condition? _____

Is there any other information you would like us to know about your child or their condition?

Parent Signature

Date

Reviewed by:

Date

Lorianne Wolfe, RN

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