

Clayton County Public Schools

Individual Health Plan

(Plan de salud individual / Kế hoạch sức khỏe cá nhân)

School _____

School Year _____

Date _____

Student Name: _____ Allergies _____ Date of Birth: _____

Teacher: _____ Grade Level: _____

Parents/Guardian: _____ Home Phone: _____

Cell Phone (Mother): _____ Work Phone (Mother): _____

Cell Phone (Father): _____ Work Phone (Father): _____

Emergency Contact: _____

Name

Relationship

Phone

Emergency Contact: _____

Name

Relationship

Phone

Physician: _____ Phone: _____

I understand that it is my responsibility as the parent/guardian of _____ to notify the school nurse/designee of any changes in my child's health condition and/or medication/treatment regimen. I authorize my child's physician and his/her staff to release the following information regarding my child's health condition. I understand that this health information will **only** be shared with pertinent school staff.

Parent/Guardian Signature

Date

Completed by Physician

Medical History:

Medical Diagnosis	Chronic/Acute	Severity	Prognosis

Description of Medical Condition (symptoms, behaviors, etc.): _____

Medication Regimen:

Medication Name	Dosage (Amount)	When to Use

Treatment Regimen/Emergency Services: _____

Individual Considerations: (Please indicate any special diet, physical activity limitations/adaptations, prosthetic devices, special procedures/interventions, and/or impact on school attendance) _____

Physician Printed Name

Physician Signature

Date