Bradley County schools Individualized Health Plan Diagnosis:_____

Student Name _____ Grade_____

Date of Birth ____/____/____ Teacher_____

To be completed by PARENT / GUARDIAN:

Illness / Medical Diagnosis requiring attention during school hours:_____

Signs / Symptoms exhibited during episode indicating need for care include:_____

Please list any related **DAILY** medications that student takes at home for condition:

_____ _____

_____ _____

Please list any medications that the student takes **AS NEEDED** to treat condition:

_____ _____

Physician managing condition: Dr._____

Phone (____) ____-____

Fax (____) ____-____

Note: Parent must provide medication in original pharmacy-labeled container. Parent / Guardian is responsible for notifying school nurse for any change in student condition or change in treatment regimen. **Parent / Guardian signature serves as consent for information to be requested from or exchanged with the physician(s) listed above.**

Parent / Guardian signature: _____Date ___/___/___

Phone:_____

TO BE COMPLETED BY PHYSICIAN:

(or attach copy of Physician Orders)

Diagnosis:_____

Actions to be taken and Medication to be administered while at school :

_____

_____

_____

_____

_____

MD Signature_____ **Date** ____/____/____

FOR SCHOOL NURSE USE ONLY:

Plan rev'd by _____Date___/___/___ MD Orders Req'd:___/___/___ Rec'd___/___/___

____Added to DD

____Medical Alert to Grade level teachers,Cafeteria Mgr., PE Teacher, and specialty teachers

Medication Location :_____