

Individualized Medical Plan

Please list all medications that the student is currently taking and the physician prescribing each one

Medication	How Often	Health Problems	Physician
1.			
2.			
3.			
4.			
5.			

Please list specialists, clinics, therapists, or other physicians consulted for your child, the problems involved, and the dates of the most recent exam.

MD or other specialist	Problem	Date last visited
1.		
2.		
3.		
4.		
5.		

May the school nurse contact any of the above listed health professionals in the event of a concern or question? Yes ____ No ____

Does the student require 1:1 care? Yes ____ No ____

Comments:

Parent's/Guardian/s Signature

Date

Physician's Signature

Date

I also give the school nurse permission to share this information with appropriate school personnel.

Parent/Guardian Signature

Date