Fife School District Special Services

MEDICAL IHP

Confidential Information

_____ School Year

Photo

Individual Health ACCOMMODATION PLAN for School

Name:	Diagnosis:	
School:	Grade:	Birth Date
Current Medications:		

EMERGENCY CONTACTS

1.	Relationship:	Phone:
2.	Relationship:	Phone:
3.	Relationship:	Phone:

MEDICAL HISTORY/INFORMATION

Accommodations as deemed appropriate:

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-
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Teachers: Please place a copy of this plan in your **substitute folder** .

ACTION PLAN

IF YOU SEE THIS	DO THIS
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•	•
•	•
•	•

- I give Health Services Staff permission **to communicate with the medical office** about this condition.
- Team members agree this student's medical condition **substantially impairs** a major life activity and is **eligible** for Section 504.
- **Various sources of information were considered**: Medical information from LHCP, Parent, Nurse and academic setting.

Parent/Guardian, Health Team Member:_____ Date:_____

School Nurse, Health Team Member: _____ Date:_____

Health Care Provider, Health Team Member: _____ Date:_____

The information from this plan will be shared with: Parent, Teacher(s), Principal, Office Staff, Transportation, and Food Service. Other: (Elementary: Specialists and Recess Personnel) (Coaches when applicable).

If sent electronically to school staff, signed original is kept in Health Room.