



## INDIVIDUAL HEALTH PLAN

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

### TO BE COMPLETED BY LICENSED HEALTHCARE PROFESSIONAL

**DIAGNOSIS:** \_\_\_\_\_

#### **Accommodations while at the school:**

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**Medication to be administered\*:**  Yes  No

If yes, list medication, administration details, potential side effects:

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\*For complete medication administration information, it will be necessary for the medical provider and parent/guardian to complete the Administration of Medicine form.

#### **Signs of medical distress:**

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#### **Suggested classroom strategies to support this child's needs:**

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#### **Potential consequences to child if treatment is not administered:**

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#### **If applicable, staff will:**

Complete a training specific to (diagnosis): \_\_\_\_\_

Be able to recognize: \_\_\_\_\_

Notify the parent/guardian if any of the following conditions exist: \_\_\_\_\_

To ensure the safety of your child we cannot delete a health care diagnosis which has previously been documented unless we have a signed note from the child's physician stating that the condition no longer exists; nor can we add an item(s) or change a medication without a signed note from the child's physician. I understand that Chestnut Hill Academy requires the most up-to-date information regarding my child's health. I also understand that for the safety of my child, my child's photograph and health information will be posted in the classrooms and kitchen.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Administrative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*This plan must be updated annually or whenever there is any change in treatment or the child's condition changes*