RANKIN COUNTY SCHOOL DISTRICT
HEALTH PLAN

DATE RECEIVED ____ / ____ / ____

TO BE COMPLETED BY PARENT OR GUARDIAN

Name _____ Age _____ Date of Birth _____

School _____ Teacher _____ Grade _____

Emergency Contact Name _____ Phone _____

IMPAIRMENT

Diagnosis _____ Date of Diagnosis _____

Brief Description:

Are acute episodes or flare up expected? ☐ Yes ☐ No

If yes, please estimate frequency and duration:

List all symptoms related to the acute episodes/flare ups:

List any known triggers of acute episodes/flare ups:

List any restrictions student must follow while at school:

List any medications:

Will the student need any medications administered at school? ☐ Yes ☐ No

If yes, please complete the Consent for Medication at School form and provide the medication to the school.

Health Care Provider _____ Health Care Provider Phone _____

TO BE COMPLETED BY THE SCHOOL WITH PARENT/GUARDIAN

STUDENT/GUARDIAN WILL:

1. Avoid known triggers.
2. Take all prescribed medications and follow plan of care.
3. Follow up with health care provider as appropriate.
4. Alert school staff immediately of any signs/symptoms of illness.

SCHOOL WILL:

1. Maintain student safety by monitoring for symptoms of health concerns.
2. Encourage student to follow plan of care.
3. Contact parent / guardian concerning student health concerns.
4. Call 911, if needed.

Parent/Guardian - Name (Print)

Parent/Guardian - Signature

School Representative - Name (Print)

School Representative - Signature