School Individual Healthcare Plan

(To be completed by a licensed practitioner)

Student's Name: _____ Date of Birth: _____ FCS Student Number: _____

Diagnosis: _____ ICD Code: _____Date form Completed: _____

CONDITION OVERVIEW / TYPICAL SYMPTOMS:

_____

_____

_____

_____

_____

DAILY CARE / INTERVENTIONS:

_____

_____

_____

INDIVIDUAL CONSIDERATIONS:

_____

_____

_____

_____

_____ Licensed Practitioner Name (PRINT) _____ Licensed Practitioner Signature & Credentials _____ Date **Licensed Practitioner Office Stamp:**	_____ Parent Name (PRINT) _____ Parent Signature _____ Date By signing above, I authorize Forsyth County School employees to contact my child's healthcare providers and/or pharmacy to obtain medical information related to my child's diagnosis, medications, treatments or any additional care required.