



Student Health Services

Individual Health Care Plan

Scholar Name: _____ Date of Birth: _____

Teacher: _____ Grade: _____ School: _____

Note: This scholar has a health condition of which the school needs to be aware. The medical diagnosis, care during school hours, emergency care, and individual considerations are stated below:

Medical Diagnosis/Condition: _____

Action Plan for School: _____

Medications (Dosage/Frequency): _____

Individual Considerations: _____

I am the parent/guardian of _____ and request that the Individual Health Care Plan be utilized during school hours.

School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this Individual Health Care Plan authorizes our Student Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Health Care Provider Signature _____ Date: _____

Physician Name (print) _____ Phone # _____

Physician Address _____ Fax _____

Parent Signature _____ Date: _____

Parent Name (Print) _____ Phone # _____

Received by _____ Date: _____

Signature and Date Reviewed by School Nurse

and Clinic Assistant: _____