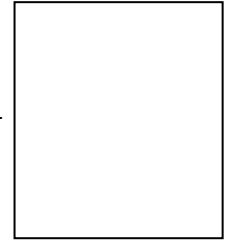


School Year _____

INDIVIDUAL HEALTH PLAN

Student Name _____ DOB _____

Teacher/ HR _____ Grade _____ Grad Year _____



PARENT / GUARDIAN EMERGENCY CONTACT INFORMATION:

Please provide phone numbers in order of where we can best reach you during the school day in case of emergency

Phone 1. _____ ☐H ☐C ☐W Name/Relationship _____

Phone 2. _____ ☐H ☐C ☐W Name/Relationship _____

Phone 3. _____ ☐H ☐C ☐W Name/Relationship _____

Address for Health Plan updates: _____

Email for Health Plan updates: _____

Condition Description: _____

Physician for this condition _____ Phone _____

Receiving medical treatment currently: ___Yes ___ No

Medication given at **school** for this condition (name, dose, frequency):

Medication given at **home** for this condition (name, dose, frequency):

NOTE: Parents are responsible for providing medication given at school. A Medication Authorization Form needs to be filled out and signed by a parent/guardian and doctor annually.

Likelihood and Frequency of Exacerbation During School Hours – Please Describe:

Desired First Aid Procedures (if any):

Please List Any Other Chronic Health Problems:

PLEASE COMPLETE AND SIGN NEXT PAGE ➔

Student Name _____

Please specify any special accommodations or concerns related to your child's health condition while at school and describe them briefly: (i.e., dietary, educational, behavior, seating, etc.)

Physical Education and Classroom Precautions (Activity restrictions specified by physician need to be in writing and signed by the doctor):

Dietary Precautions:

Sport Precautions:

Recess Precautions:

Special Considerations for Field Trips:

Other relevant information related to the health condition or student's health history:

This plan and medication will be used in case of emergency and accompany student off school property. This information may be shared with the classroom teacher(s), administrators, aides, and other appropriate school personnel with a need to know.

Parent/Guardian Signature: _____ Date _____

School Nurse: _____ Date _____

Health Care Provider Signature: _____ Date _____
(if necessary)