

INDIVIDUALIZED HEALTH CARE PLAN

Student's Name: _____

Date of Birth: _____

Grade: _____

PARENTS

Mother's Name: _____

Mother's Address: _____

Mother's Home Phone: _____ Work Phone: _____ Emergency Phone: _____

Father's Name: _____

Father's Address: _____

Father's Home Phone: _____ Work Phone: _____ Emergency Phone: _____

PHYSICIAN

Physician's Name: _____ Telephone: _____

Physician's Address: _____

HOSPITAL

Hospital Emergency Room: _____

Hospital Address: _____

The closest hospital

Hospital Phone: _____

MEDICAL OVERVIEW

Medical Conditions: _____

Any Known Allergies: _____

Medications: _____

Health Care plan needed for period of _____ to _____.

HEALTH CARE ACTION PLAN

Attach physician's order and other standards for care.

PROCEDURE:

EQUIPMENT:

ADMINISTERED BY:

1. _____

2. _____

3. _____

4. _____

HEALTH CARE ACTION PLAN (cont.)

Medications:

Attach medication order and medication administration plan

Diet:

Check if additional information is attached.

Transportation:

Check if additional information is attached.

Classroom/School Modifications (including adapted PE):

Check if additional information is attached.

List of Equipment/Supplies:

Provided by:

1. _____
2. _____
3. _____

None Required

Specific Safety Measures:

Next review date for plan:

Training:

Possible Problems to be Expected:

DOCUMENTATION OF PARTICIPATION

We, the undersigned, have participated in the development of the Health Care Plan and agree with its contents.

Signature

Date

Administrator or Designee

Nurse

PARENT AUTHORIZATION FOR SPECIAL HEALTH SERVICES

We (I), the undersigned who are the parents/guardians of _____, _____
(Student name) (Birth date)
request and approve the attached Individualized Health Care Plan. We (I) understand that a qualified person(s) will be performing the health care service. It is our (my) understanding that in performing this service, the designated person(s) will be using a standard procedure which has been approved by the student's Health Care Team and Physician.

We (I) will notify the school immediately if the health status of _____ changes, we (I)
(Student name)
change physicians, or there is a change or cancellation of the procedure.

We (I) agree to provide the following, if any medical equipment and supplies, medication, dietary supplements.

<p>_____ Parent/Guardian Signature</p> <p>_____ Print Name</p> <p>Date _____</p>	<p>_____ Parent/Guardian Signature</p> <p>_____ Print Name</p> <p>Date _____</p>
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Teachers, please sign below that you have read this individualize health care plan.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____