ORTHOPEDIC INDIVIDUAL HEALTH PLAN

(Parent/guardian to complete this form)

STUDENT NAME _____ DOB _____ SCHOOL _____

GRADE _____ TEACHER _____ SCHOOL YEAR _____

PARENT/GUARDIAN _____ BEST CONTACT/PHONE NUMBER _____

PHYSICIAN _____ PHONE _____

SPECIALIST _____ PHONE _____

What is the name of your child's orthopedic condition?

Please describe your child's orthopedic condition:

Has your child ever had a surgery or surgeries for this condition? ☐ Yes ☐ No If yes, please describe:

Does your child take a medication at home every day for this condition? ☐ Yes ☐ No If yes, what medication?

Does your child have a doctor's order for medication for this condition to be given at school, and is the medication at school?
☐ Yes ☐ No

Does your child require any assistive devices due to this condition? ☐ Yes ☐ No If yes, please list devices:

Does your child currently have physical therapy (PT) or occupational therapy (OT) services? ☐ Yes ☐ No
If yes, please explain and include where they are getting these services, such as at school or another agency.

Has your child needed emergency room treatment for this condition within the past year? ☐ Yes ☐ No
If yes, please describe:

In the event that you cannot be reached, please list the name(s) and phone number(s) of persons who are familiar with your child's condition and have knowledge of how to manage this condition. *Please also add this person(s) to your child's pick-up list in case they may need to pick your child up from school due to their condition.*

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Is there anything else you would like school staff to know about your child's condition?

PLEASE NOTE: We recommend talking with your child's doctor to see if they recommend an Emergency Action Plan.

☐ I give permission for my child, _____, to receive care for the medical condition listed above by designated school staff.

☐ School nurse may share information regarding this condition with my child's doctor.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

SCHOOL NURSE SIGNATURE _____ DATE _____