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 condition?

Please describe your child's condition.

Has your child ever had a surgery or surgeries for this condition? 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 to be given at school for this condition, and is the medication at school?
☐ Yes ☐ No

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 _______________

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