Individualized Health Plan

Student: _____ **Grade:** _____

Student & Contact Information

Student Name: _____ **DOB:** _____

Address: _____ **City/State/Zip:** _____

Home Phone: _____ **Cell Phone:** _____

School: _____ **Teacher:** _____ **Bus:** _____

Emergency Contact(s): **Phone Number(s):**

1st Contact: _____ _____

2nd Contact: _____ _____

Parent/Guardian: _____ **Principle Name:** _____

MEDICAL HISTORY:

MEDICAL CONDITION: _____

ANY KNOWN ALLERGIES: _____

MEDICATIONS:	**POSSIBLE SIDE EFFECTS:**
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____

INTERVENTIONS:

1. _____

2. _____

3. _____

4. _____

(Continue to next page for Parent/Guardian Signature)

Individualized
Health Plan

Parental Authorization for Health Services

My signature below provides authorization for the Individualized Care Plan contained herein. I/We understand that all treatments and procedures may be performed by the school nurse, the student, and/or trained, unlicensed designated school personnel as allowed by school policy or by Emergency Medical Services in the event of loss of consciousness or seizure.

Initial and sign below:

____ I also give permission for the school and school nurse to contact the health care provider regarding these orders and administration of these medications.

____ I will notify the school immediately if the health status of _____ changes, we change physicians, or there is a change or cancellation of the procedure.

____ I agree to provide the medication and/or supplies, in a timely manner.

❖ _____ _____

(Signature of Parent/Guardian) **(Date)**

Documentation of Participation and Acknowledgement of Plan

Trained/Reviewed Use of Emergency Medications:

Title	Name	Date
Principal		
Assistant Principal		
Nurse		
Clinic Backup		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		
Teacher		