Individual Health Care Plan

Photo of student

This form must be completed fully in order for schools to carry out the requested plan of care. A health care plan must be completed at the beginning of each school year and each time there is a change in the plan of care.

School: _____Grade:_____ Teacher: _____
This order is valid only for school year (current) _____including the summer session.

This section to be completed by health care provider

Name of student:	**DOB:**
Medical Diagnosis and health condition(s):	
Usual treatment/ medications at home:	
Procedure(s) to be performed at school:	
Medication(s) to be administered at school:	
Other support needed at school:	
Signs of emergency:	
Actions personnel should take during emergency:	
Functional limitations:	
Additional instructions:	

Provider's Name/Title: _____
Type or Print
Telephone: _____Fax: _____
Address: _____
_____
Provider's Signature: _____Date: _____
(*Original signature or signature stamp only)*

(Use for Provider's Address Stamp)

Parent/Guardian Authorization

I/We request designated school personnel to administer and/or perform the treatment as prescribed by the above provider. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication and/or medical treatments at school. I/we understand that at the end of the school year, an adult must pick up the medication, otherwise, it will be discarded. I/we authorize the school nurse to communicate with the health care provider as allowed by HIPPA.

Parent/Guardian Signature: _____Date: _____
Home Phone: _____Cell Phone: _____Work Phone: _____

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