



Individualized Health Care Plan

Identifying Information

Student's Name: _____ School: _____

Birth Date: _____ Age: _____

Teacher(s): _____

Class: _____

Contacts

Parents/Guardian

Name: _____

Address: _____

Phone: Home: _____ Work: _____ Emergency/Cell: _____

Name: _____

Address: _____

Phone: Home: _____ Work: _____ Emergency/Cell: _____

Health Care Provider:

Health Care Provider Address: _____

Phone: _____

Hospital Emergency Room: _____

Phone: _____

Hospital Address: _____

Ambulance Service: _____

Phone: _____

Medical Overview

Medical Condition: _____

Known Allergies: _____

Medications: _____

Possible Side Effects: _____

Necessary Health Care Procedures at School: _____

Health Care Plan effective Dates: From _____ to _____

Other Important Information

Background Information

Brief Medical History: _____

____ Check if additional information is attached.

Specific Health Care Needs:

____ Check if additional information is attached.

Social/Emotional Concerns:

____ Check if additional information is attached.

Health Care Action Plan

Attach the health care provider's order and other standards for care.

Procedure	Administered by	Equipment	Maintained by	Authorized/Trained by

School Representative: _____ Date: _____

Parent/Guardian: _____ Date: _____