SCHOOL INDIVIDUALIZED HEALTH CARE PLAN

Student: _____ School: _____

Meeting Date: _____ Effective Plan Date: _____

Parent Name: _____ Contact #: _____

Parent Name: _____ Contact #: _____

Physician Name: _____ Physician's Clinic: _____

School Nurse: _____ Contact #: _____

I. Medical Reports Received:

II. List Medical Concerns:

1.

2.

3.

III. At School (including lunch, recess, field trips, etc.)

Please document detailed description of each Medical Concern (listed above) including school & staff responsibility.

1.

2.

3.

IV. The school staff will be trained regarding medical concerns and school procedures. COPIES OF TRAINING/SIGN IN SHEETS will be on file.

V. If 911 is called, parents are called immediately after (follow emergency school procedures).