Confidential Individualized Healthcare Plan

Student Name:_____ DOB: _____

Parent/Guardian: _____

Parent/Guardian: _____

Healthcare Provider: _____

Preferred Hospital: _____

Emergency Contact: _____

Pertinent Health History:

_____

_____

Current Medications:

AT HOME:	SCHOOL:

Allergies: _____

Restrictions: _____

Health Problems:

Problem:	**Goal:** **Action:**
Problem:	**Goal:** **Action:**

EMERGENCY ACTION PLAN:

_____

_____

I give permission for school personnel to share information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medications and equipment devices. I approve this Individualized Healthcare Plan for my child.

Parent/Guardian: _____ Date: _____
Student: _____ Date: _____
Office Manager: _____ Date: _____