Health Care Plan

Student's Name _____ Birthdate _____

School _____ Grade _____ Height _____ Weight ____

Description of illness or condition

_____

_____

_____

_____

_____

_____

Personnel who are trained. Indicate date and type of training.

_____

_____

_____

_____

Time schedule and/or indication for health care

_____

_____

_____

Action required and degree of urgency

_____

_____

_____

_____

Emergency information

Parents, legal guardians or other designated responsible adult and doctor

1. _____ _____ _____ _____

2. _____ _____ _____ _____

3. _____ _____ _____ _____

4. _____ _____ _____ _____

5. _____ _____ _____ _____

6. _____ _____ _____ _____

Transportation Plan

_____

_____

_____

_____

_____

_____

_____

Health Care Plan for this student to be discontinued or re-evaluated on this date: _____

_____ _____

Parent's Signature Date

_____ _____

School registered nurse Date

_____ _____

Doctor's signature (if appropriate) Date