TO BE MAINTAINED IN PERMANENT RECORD. DO NOT DESTROY.

School Health Care Plan

Name of Student: _____ Date of Birth: _____

Dear Parent:
We understand that your child has _____.
Please complete this form and return it to school. If your child needs medication at school, we must have a completed medication authorization form. It is your responsibility to inform after school staff regarding your child's medical needs. This Care Plan will be maintained on file for your student. If any changes need to be made to this Care Plan, please notify your School Nurse.

_____

School Nurse Phone

Describe your child's health condition/any related symptoms:

_____

_____

Current medications:

_____

_____

Are there any special instructions or restrictions related to this condition?

_____

_____

Health Care Provider Name _____ Phone _____

Has your child been seen by the health care provider for this condition in the past 12 months?
Yes ___ No ___ Hospitalized? Yes ___ No ___

Any other information that would be helpful to the school:

_____

_____

If at some future date any of this information changes, please notify the school. Please sign below, indicating your consent that I can contact your child's health care provider.

Parent/Guardian Signature _____ Date _____
Phone (home) _____ (work) _____
Date Completed _____

Teachers are responsible for establishing a means of notifying all others who may assume responsibility for this student (teacher assistants, substitute teachers, specialty teachers), that this plan exists.