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| [Type the company name]  *Photo of student*  **Individual Health Care Plan**  ***This form must be completed fully in order for schools to carry out the requested***  ***plan of care. A health care plan must be completed at the beginning of each***  ***school year and each time there is a change in the plan of care.***  School: \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_Grade:\_\_\_ \_\_\_\_\_ Teacher: \_\_\_\_ \_\_\_\_\_\_\_\_  This order is valid only for school year (current) including the summer session.  ***This section to be completed by health care provider***   |  |  | | --- | --- | | **Name of student:** | **DOB:** | | **Medical Diagnosis and health condition(s):** |  | | **Usual treatment/ medications at home:** |  | | **Procedure(s) to be performed at school:** |  | | **Medication(s) to be administered at school:** |  | | **Other support needed at school:** |  | | **Signs of emergency:** |  | | **Actions personnel should take during emergency:** |  | | **Functional limitations:** |  | | **Additional instructions:** |  |   Provider’s Name/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Type or Print*  Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Provider’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_  (*Original signature or signature stamp only) (Use for Provider’s Address Stamp)*  **Parent/Guardian Authorization**  ***I/We request designated school personnel to administer and/or perform the treatment as prescribed by the above provider. I/We certify that I/we have legal authority to consent to medical treatment for the student named above, including the administration of medication and/or medical treatments at school. I/we understand that at the end of the school year, an adult must pick up the medication, otherwise, it will be discarded. I/we authorize the school nurse to communicate with the health care provider as allowed by HIPPA.***  Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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**Individual Health Care Plan**

