|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| [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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [Type the document title] |
| [Type the document subtitle] |
|  |
| **heather.peters** |
| **[Pick the date]** |

|  |
| --- |
| [Type the abstract of the document here. The abstract is typically a short summary of the contents of the document. Type the abstract of the document here. The abstract is typically a short summary of the contents of the document.] |

**Individual Health Care Plan**

