HEALTH CARE PLAN FOR STUDENTS WITH COMPLEX HEALTH NEEDS

NAME	**DATE**	
DATE OF BIRTH	**WEIGHT**	**GRADE/ CLASS**
ALLERGIES:		

MEDICAL CONDITIONS/ HEALTH CONCERNS

1
2
3
4

MEDICATIONS

DAILY	**PRN (INDICATE HOME/SCHOOL)**
1	**1**
2	**2**
3	**3**
4	**4**

PARENT CONSENT: I authorize school personnel to administer the prescribed medication(s) indicated and to provide care to my child in school and on field trips.

_____ _____

SIGNATURE **DATE**

PARENT NAME AND EMERGENCY TELEPHONE NUMBERS

NAME	HOME #
	WORK #
RELATIONSHIP	CELL/OTHER#
NAME	HOME #
	WORK #
RELATIONSHIP	CELL/OTHER#
ALTERNATE EMERGENCY CONTACT	HOME #
NAME	WORK #
RELATIONSHIP	CELL/OTHER#
ALTERNATE EMERGENCY CONTACT	HOME #
NAME	WORK #
RELATIONSHIP	CELL/OTHER#

PHYSICIAN/NURSE NAMES/TELEPHONE NUMBERS	
PHYSICIAN	PHONE #
NURSE	PHONE #
PHYSICIAN	PHONE #
NURSE	PHONE #

SCHOOL PERSONNEL TRAINED TO PROVIDE CARE FOR STUDENT	
NAME	CL./POSITION
NAME	CL./POSITION
NAME	CL./POSITION

BRIEF HEALTH HISTORY

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SPECIAL HEALTH CARE NEEDS

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STUDENT PARTICIPATION / FIELD TRIPS

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OTHER CONSIDERATIONS

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SUBSTITUTE CARE GIVER 1	SUBSTITUTE CARE GIVER 2
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ADDITIONAL INFORMATION

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