School Health Plan of Care

Name: _____ DOB: _____ School: _____ Grade: _____
Parent/ Guardian: _____ Phone #: _____ Work#: _____
Emergency contact if parent is not available: _____ Phone #: _____
Primary Physician: _____ Phone#: _____ Preferred Hospital: _____
School Nurse: _____
Other pertinent information: _____

Medical Diagnosis: _____ Allergy to any medications: __ Yes ___No
Allergic to: _____

Current Medications (include dosages and times): _____
_____
_____

Assessment/ Physician orders: _____
_____
_____
_____

Actions:
_____
_____
_____

Other: _____
_____
_____

Please list circumstances under which: **the parent should be called**: _____
_____
Or 911 should be called_____
_____

This plan is in accordance with the student's medical management.

Physician's Signature: _____ Date: _____

I give permission for school personnel to provide emergency treatment to my child as specified in the above plan. I understand it is my responsibility to provide any medication needed by my child at school. I agree to notify the school if a change occurs in my child's conditions and I agree to allow this information to be shared with the adults responsible for my child's care (parent to receive a copy of this plan).
Parent/Guardian Signature: _____Date: _____

I have reviewed the health plan of care for this student with the parent, teacher(s), physical education instructor, bus driver (as needed), and staff needed to assist with the student's care while in school.
School Nurse Signature: _____ Date: _____
School: _____ Teacher: _____