# Confidential Individualized Healthcare Plan

**Student Name:** **Birth Date** **School** **Grade** **Student #**

| | |
|---|---|
| **Parent/Guardian**: | **Name & Phone #** |
| **Parent/Guardian**: | **Name & Phone #** |
| **Healthcare Provider** | **Primary Care Provider & Phone #** |
| **Healthcare Provider** | **Specialist & Phone #** |
| **Preferred Hospital:** | **Preferred Hospital** |
| **Emergency Contact:** | **Name, Relationship & Phone #** |
| **CURRENT HEALTH ISSUES** | |
| **PERTINENT HEALTH HISTORY** | |
| **CURRENT MEDICATIONS:** | **AT HOME:**<br>**AT SCHOOL:** |
| **ALLERGIES:** | |
| **RESTRICTIONS:** | relevant activity/diet |
| **CURRENT MEDICATIONS:** | **AT HOME** |
| | **AT SCHOOL:** |
| **HEALTH PROBLEM(S):** | |
| **Problem:** | **Goal:**<br>**Action:**<br>☐ |
| **Problem:** | **Goal:**<br>**Action:**<br>☐ |
| **Problem:** | **Goal:**<br>**Action:**<br>☐ |
| **EMERGENCY ACTION PLAN** | |

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and equipment devices. I approve this Individualized Healthcare Plan for my child.

parent/guardian date

health care provider date

student (optional) date

school nurse date

administrator date