General Healthcare Plan

School Year: _______________

Name:	**DOB:**	**School:**	**Grade:**
Parent/Guardian:	Phone:	Email:	
Additional Contact:	Phone:	Work Phone:	
Healthcare Provider:	Phone:	Fax:	

Medical Diagnosis:	
Allergies:	
Pertinent Health History:	
Current Medication, ***Dosage and Times*****:**	
Specific Healthcare Needs, Goals, Assessment and Actions: ____ ____ ____ ____ ____ ____ ____ ____	
Potential Problems:	
Call parents if:	**Call 911 if:**

I give permission for school personnel to share this information, follow this plan, administer medication, 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 Physician signature Date