Spencer County Public Schools Health Services

INDIVIDUAL HEALTH CARE PLAN

Must be completed by a
Licensed Health Professional

PRINT Student Name: _____ School Year_____
Date of Birth: _____ Teacher/Grade_____
Date of Diagnosis: _____ Bus Route # _____

Emergency Contacts:

Name: _____ Numbers: _____
Name: _____ Numbers: _____
Name: _____ Numbers: _____

PRINT Treating Physician Name:_____ Number: _____
Physician Address: _____ FAX # _____

MEDICAL DIAGNOSIS: _____

Symptoms of occurrence/adverse reaction:

_____

_____

Procedure(s) to follow in emergency:

_____

_____

Will student need medication(s) / device(s) at school ___No ___Yes

Please list all medication(s) / medical device(s) prescribed for home and/or school:

_____

_____

***NOTE: Parent and Physician must complete a Permission for Prescribed or Over-the the Counter Medication Form for each medication needed at school.**

Additional instructions/comments:

_____

_____

PHYSICIAN/MEDICAL Signature _____ Date _____

PARENT Signature _____ Date _____

STAFF/SCHOOL NURSE Signature _____ Date_____