INDIVIDUALIZED HEALTH MANAGEMENT PLAN FOR:

____
(Health Diagnosis)

SCHOOL YEAR: ________

STUDENT NAME:	**DOB:**
SCHOOL:	**STUDENT ID:**

Parent/Guardian	**Parent/Guardian**
Phone:	**Phone:**
Phone:	**Phone:**
Emergency Contact:	
Name:	**Phone:**
Physician:	**Phone:**
Hospital Preference:	

Diagnosis:____

Student History:

Medications (list all medications taken):	**Dose:**	**Time:**

SCHOOL MANAGEMENT:

CALL PARENT/GUARDIAN:

CALL 911:

School Clinic: Copy of this plan to be provided to Transportation Supervisor.

______________________________ ______________________________
PARENT/GUARDIAN SIGNATURE DATE CLUSTER NURSE SIGNATURE DATE

Information about students and family is strictly confidential.

Rev. 2/2024