

Individualized Health Management Plan for _____

SCHOOL YEAR: _____

Student Name:	DOB:
School:	Student ID:

CONTACTS:	
Parent/Guardian:	Parent/Guardian:
HOME:	HOME:
WORK:	WORK:
CELL:	CELL:
If parents cannot be reached call:	
Name:	Phone:
Name:	Phone:
Physician:	Phone:
Hospital Preference:	

Diagnosis: _____ Student History:		
Medications (list all medications taken):	Dose:	Time:
SCHOOL MANAGEMENT:		

CALL PARENTS:
CALL 911:

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

PARENT SIGNATURE / DATE

COUNTY SCHOOL NURSE SIGNATURE / DATE

Information about students and family is strictly confidential.

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