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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