Florence High School

Confidential Individualized Healthcare Plan

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2017/2018

Student Name: **Birth Date** **School** **Grade** **Student #**

Parent/Guardian:	
Parent/Guardian:	
Healthcare Provider	
Healthcare Provider	
Preferred Hospital:	
Emergency Contact:	
CURRENT HEALTH ISSUES	
PERTINENT HEALTH HISTORY	
CURRENT MEDICATIONS:	**AT HOME:** **AT SCHOOL:**
ALLERGIES:	
RESTRICTIONS:	
HEALTH PROBLEM(S):	
Problem:	**Goal:** **Action:** ☐
Problem:	**Goal:** **Action:** ☐
Problem:	**Goal:** **Action:** ☐
EMERGENCY ACTION PLAN	

I give permission for school personnel to share this information, follow this plan, administer medication and 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

school nurse date

health care provider date

administrator date

student (optional) date