

Penrose Elementary School
Confidential Individualized Healthcare Plan
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2017/2018
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<u>Student Name:</u>	<u>Birth Date</u>	<u>School</u>	<u>Grade</u>	<u>Student #</u>
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:		
		<input type="checkbox"/>		
Problem:		Goal:		
		Action:		
		<input type="checkbox"/>		
Problem:		Goal:		
		Action:		
		<input type="checkbox"/>		
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

 health care provider date

 student (optional) date

 school nurse date

 administrator date