

SE29			
<input type="checkbox"/>	TDR	<input type="checkbox"/>	Nurse
<input type="checkbox"/>	Administration	<input type="checkbox"/>	Gen. Ed.
<input type="checkbox"/>	Transportation Director		

HEALTH CARE PLAN

Student:			Conference Date:	
Attending School:			Date of Birth:	
Grade:				
Primary Parent/Guardian:				
Address:				
Home Phone:		Work Phone:		Cell Phone:

Persons to be notified in case of emergency (other than parents/guardians)

Name	Relationship	Primary Phone	Other Phone

Primary Doctor Name:			
Address:			
Telephone:		FAX:	
Additional Doctor Name:			
Address:			
Telephone:		FAX:	

<u>MEDICAL INFORMATION</u>	Date of last physical examination:	
<u>Current Diagnosis (including allergies), Description of Health Condition, Symptoms:</u>		
<u>Precautions to be taken:</u>		

Medication Name	Purpose/Description	Dosage	Time Given	Person Responsible	Precautions	Side Effects

List any equipment needs:

Medical Interventions Needed During School Hours:

Symptoms Requiring Intervention	
Intervention to be Implemented	
Training Required	
Interventions performed by whom	
Comments/Narrative	

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Intervention to be Implemented	
Training Required	
Interventions performed by whom	
Comments/Narrative	

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Intervention to be Implemented	
Training Required	
Interventions performed by whom	
Comments/Narrative	

In the event of an emergency, student will be transported by ambulance to the nearest available hospital.

In case of an emergency, all reasonable efforts will be made by school personnel to preserve the student's well-being until medical personnel are available.

Date to be reviewed: _____