

Central Day School
2005 Winchester Blvd.
Collierville, TN 38017
901-255-8205
www.centraldayschool.com

Individualized Health Care Plan

I. IDENTIFYING INFORMATION

Student's Name	School
Birthdate	Teacher
Age	Grade

CONTACTS

PARENTS

Mother's Name _____

Mother's Address _____

Mother's Home Telephone _____ Work Telephone _____ Cell Phone _____

Father's Name _____

Father's Address _____

Father's Home Telephone _____ Work Telephone _____ Cell Phone _____

PHYSICIAN

Physician _____ Telephone _____

Physician Address _____

EMERGENCY CONTACT INFORMATION

Name _____ Telephone _____

Address _____

Name _____ Telephone _____

Address _____

II. MEDICAL OVERVIEW

Medical Condition _____ Any Known Allergies _____

Medications _____

Possible Side Effects _____

Necessary Health Care Procedures at School _____

Health Care Plan for Period _____ to _____

III. OTHER IMPORTANT INFORMATION

IV. BACKGROUND INFORMATION/ASSESSMENT

Brief Medical History

Check if additional information is attached.

Specific Health Care Needs

Check if additional information is attached.

Possible Variations to Social/Emotional/Behavior

Check if additional information is attached.

Possible Variations to Academic/Classroom Achievement

Check if additional information is attached.

V. HEALTH CARE ACTION PLAN

Attach physician's order and other standards for care.

Procedures and Interventions (student specific)

Procedure	Administered by	Equipment	Maintained by	Auth/trained by
1.				
2.				
3.				

V. HEALTH CARE ACTION PLAN (cont.)

Medications

Attach medication form and administration log.

Diet

Check if additional information is attached.

Classroom School Modifications (including adapted PE)

Check if additional information is attached.

Other Needs

Check if additional information is attached.

Equipment—List necessary equipment/supplies

Provided by Parent

Provided by School

1.

2.

3.

4.

None Required

Safety Measures

Check if additional information is attached.

Emergency Plan Attached

Transportation Plan Attached

Training Plan Attached

Substitute/Backup Staff (when primary staff not available)

Possible Problems to be Expected

Training

VI. HEALTH CARE PLAN REVIEW

Next review date of Health Care Plan _____

VII. DOCUMENTATION OF PARTICIPATION

We have participated in the development of the Health Care Plan and agree with its contents.

Signature

Date

_____ Administrator or Designee

_____ Other

_____ Other

VIII. PARENT AUTHORIZATION FOR SPECIAL HEALTH SERVICES

We (I), the undersigned who are the parents/guardians of _____, _____
(Student Name) (Birthdate)

request and approve the attached Individualized Health Care Plan. We (I) understand that a qualified designated person(s) will be performing the health care service. It is our understanding that in performing this service, the designated person(s) will be using a standardized procedure which has been approved by the student's Health Care Team and Physician.

We (I) will notify the school immediately if the health status of _____
(Student Name)

changes, we change physicians, or there is a change or cancellation of the procedure.

We (I) agree to provide the following, if any: medical equipment and supplies, medication, dietary supplements.

My electronic signature below authorizes the school to provide this service in accordance with the procedures contained within.

Parent Signature

Date _____

Parent Signature

Date _____