

HEALTH CARE PLAN

Student Name: _____ Date: _____

Date of Birth: _____ Address: _____

Father: _____ Home Phone: _____ Work Phone: _____

Mother: _____ Home Phone: _____ Work Phone: _____

Pager #: _____ Cell Phone: _____

Primary Caregiver (if needed): _____ School: _____

Teacher(s): _____ Grade/Class: _____

Physician(s): _____ Phone: _____

Hospital: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Daycare: _____ Phone: _____

PERTINENT MEDICAL HISTORY AND DIAGNOSIS (Including Allergies, hospitalizations & surgeries)

HEALTH ACTION/EMERGENCY HEALTH PLAN

EMERGENCY EVACUATION PLAN

Student Name

Date of Conference

VISION/HEARING/MEDICAL EQUIPMENT

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COMMUNICATIVE ABILITIES & INFORMATION & COMMUNICATION DEVICES

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ADDITIONAL COMMENTS OR CARE INFORMATION (Include toileting, feeding, nutrition, etc.)

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MEDICATION

	Name of Medication	Dosage	Schedule
1.			
2.			
3.			
4.			
5.			
6.			

TREATMENT(S)

TYPE	TIME/FREQUENCY	SPECIAL INSTRUCTIONS