

Individual Health Plan (IHP) - CONFIDENTIAL

Health Issue: _____

Student Information:

Name: _____ Date of Birth: _____
School: _____ Grade: _____ Teacher: _____

Emergency Information:

Parent(s) Names: _____
Mother's Telephone (W): _____ Father's Telephone (W): _____
Telephone (H): _____ Telephone (H): _____
Primary Care Physician: _____ Telephone: _____
Specialist: _____ Telephone: _____

In the event a parent/guardian cannot be reached:

Name: _____ Relation: _____ Telephone: _____
Name: _____ Relation: _____ Telephone: _____

Medical History:

Diagnosis: _____

Allergies: _____

Current Medications:

Please list the precautions related to student's health issue: _____

Plan: _____

I have reviewed and agree with this plan of care.

Physician Signature _____ **Date:** _____

I understand that it is my responsibility to keep this information current. Please notify School Nurse and provide an updated/current form on at least an annual basis.

Parent's/Guardian's Signature: _____ **Date:** _____

Reviewed By: _____ **Date:** _____

Medication at school

Required equipment at school

Medication at school

Required equipment at school