Academy School District 20 General Health Care Plan

Name_____Birthdate_____Grade_____
Teacher_____School_____Date_____
Physician_____Phone_____
Parent_____Phone(s)_____
Medications taken at home_____
Medications taken at school_____
(Include dosage and frequency. If "as needed," also indicate how frequently medication may be repeated.)

Health condition or diagnosis_____

_____

Symptoms may include_____

_____

_____

Action plan_____

_____

_____

_____

**I give my permission for the information on this Health Care Plan to be shared with adults in the school setting that will be working with my child on a need-to-know basis, including Transportation.
**This Health Care Plan will remain in effect for the current school year.
**It is the responsibility of the parent to notify the school nurse whenever there is a change in the student's health status or care.

Parent_____Date_____

Physician_____Date_____

School Nurse _____Date_____ Updated 05-08-15