

General Health Care Plan

Student Name: _____ School _____

DOB: _____ Classroom _____ Teacher _____

Physician: _____ Phone _____

Parents/Guardian Names: _____

Home Phone # _____ Cell Phone # _____

Mom's work phone _____ Dad's work phone _____

Health Condition(s): _____

Symptoms: _____

Center Personnel Action (What to do):

Medication(s) Home:

Medication(s) at Center:

Additional Information: _____

Parents agree to have this information shared with necessary Center personnel to ensure your child's health safety.

_____ Parent Signature _____ Date

_____ Physician Signature _____ Date

_____ Nurse Consultant _____ Date

***This Health Care Plan and any nurse delegation related to this plan are for use during regular school hours (8:10 a.m. – 3:20 p.m.). Medication questions outside of regular school hours need to be referred to the child's parents, Poison Control or 911. If a parent can attend a before/after school activity, they can assume responsibility for the medication.**