

St Peter Catholic School
Confidential Individualized Healthcare Plan
 Tara Cuccinelli RN, MS, CNS 719-481-1855

2021-2022
 Page 1 of 1

Student Name:

Birth Date

Grade

Parent/Guardian:	Name & Phone #
Emergency Contact:	Name, Relationship & Phone #
CURRENT HEALTH ISSUES	
PERTINENT HEALTH HISTORY	
CURRENT MEDICATIONS:	AT HOME: AT SCHOOL:
ALLERGIES:	
RESTRICTIONS:	relevant activity/diet
ADDITIONAL INFORMATION:	
HEALTH CONCERN(S):	To be completed by nurse
Concern:	Goal: Action: <input type="checkbox"/>
Concern:	Goal: Action: <input type="checkbox"/>
Concern:	Goal: Action: <input type="checkbox"/>
This service is medically necessary through the following dates, not to exceed one year. Start Date: _____ End Date: _____	

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and equipment devices. I approve this Individualized Healthcare Plan for my child.

 parent/guardian date

 health care provider
 date

 student (optional)
 date

 school nurse date

 administrator
 date