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.**