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.
**This Health Care Plan and any nurse delegation related to this plan are for use during normal operational school hours. After hours, call 911 and parent(s) for any medical emergencies or concerns.

Parent_____Date_____

Physician_____Date_____

School Nurse_____Date_____

Updated 05-08-13