INDIVIDUALIZED HEALTH CARE PLAN

SCHOOL YEAR_____ CAMPUS_____

NAME: DOB: Regular IHCP ❑ 504 IHCP ❑

HEALTH CONCERN(S)/ DIAGNOSIS:

Health Action Plan:

FOOD OR DRUG ALLERGIES:

DIETARY CONCERNS/RESTRICTIONS:

EMOTIONAL/ BEHAVIORAL CONCERNS:

Medications:	**Dose/Time:**

Parent Signature: **Date**:

M.D. Signature (or Med. Authorization form): **Date**:

Physician Name (PRINTED):

CONTACT INFORMATION

Parent/Guardian:

1._____

2._____

Home phone:

Work:_____ Cell:_____

Work:_____ Cell:_____

Emergency Contact: **Teacher**:

Emergency Contact: **Phone:**

Copies: □ Parent □ Teacher _____ □ PE □ Library □ Music □ Transportation □ Nurse □ Cafeteria

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