

INDIVIDUALIZED HEALTH CARE PLAN

NAME: _____ DOB: _____ SEX: _____ ALLERGIES: _____ PHYSICIAN: _____

RELEVANT DIAGNOSIS: _____

DIET: _____ MOBILITY: _____ EQUIPMENT: _____

MEDICAL HISTORY: _____

MEDICATION/TREATMENT: _____

SIGNATURE: _____ (Parent) SIGNATURE: _____ (Student) SIGNATURE: _____ (School Nurse)

LIAISON WITH FAMILY: _____ DATES OF MEDICAL ORDERS: _____ / _____ / _____

DATE	HEALTH PROBLEM/NURSING DIAGNOSIS	STUDENT GOALS	INTERVENTION AND RESPONSIBLE PERSON	EVALUATION AND TIMELINE