INDIVIDUAL HEALTH PLAN: _____

(Parent/guardian to complete this form)

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PHYSICIAN SPECIALIST What is the name of your child's condition? Please describe your child's condition. Has your child ever had a surgery or surgeries for this condition? If yes, please describe: Does your child take a medication at home every day for this condition? If yes No If yes, what medication? Does your child have a doctor's order for medication to be given at school for this condition, and is the medication at school? Yes No Has your child needed emergency room treatment for this condition within the past year? I Yes No If yes, please describe: In the event that you cannot be reached, please list the name(s) and phone number(s) of persons who are familiar with your child's condition and have knowledge of how to manage this condition. Please also add this person(s) to your child's pick-up list in case they may need to pick your child up from school due to their condition. Name: Phone Number: P	DADENIT/OT	TADDIAN	BEST CO	NIACI/PHONE NOWIDER	
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