

**ST. CHARLES SCHOOL
INDIVIDUALIZED HEALTH PLAN**

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IDENTIFYING INFORMATION:

Student:	DOB:	Home Phone:
Mother:	Work Phone:	Cell Phone:
Father:	Work Phone:	Cell Phone:
School:	Phone:	
Physician:	Phone:	Fax:

HEALTHCARE INFORMATION:

Hospital of choice:

Health concern:

Date of diagnosis:

Routine management of condition:

MEDICATIONS:

Medications to be given during school hours:

Dosage:

Time to be given:

Other pertinent information:

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AGREEMENT FOR CARE

As a parent of _____, I hereby give my permission to trained staff at ST. CHARLES SCHOOL to perform and carry out the tasks as outlined in this Individualized Health Plan (IHP). I understand that the information contained in this plan will be shared with school staff only on a need-to-know basis. It is the responsibility of the parent to notify the school whenever there is any change in the student's health status or care.

Mother (Guardian): _____ Date: _____

Father (Guardian): _____ Date: _____

IHP Developed by:
Physician: _____ Date: _____
(Nurse Practitioner, Registered Nurse, or other licensed healthcare professional)

I have reviewed this Individualized Health Plan and accept the plan of care for this student during school hours.

Principal: _____ Date: _____
