Catoosa County Public Schools
Individual Health Plan

School_____

School Year_____ **Date**_____

Student Name: _____ Date of Birth: _____
Teacher:_____ Grade Level: _____
Parents/Guardian: _____ Work Phone (Mother)_____
Home Phone: _____ Work Phone (Father)_____
Cell Phone: _____

Emergency Contact: _____
Name Relationship Phone
Emergency Contact: _____
Name Relationship Phone

Physician: _____ Phone: _____

I understand that it is my responsibility as the parent/guardian of _____ to notify the school nurse / designee of any changes in my child's health condition and / or medication / treatment regimen. I authorize my child's physician and his / her staff to release the following information regarding my child's health condition. I understand that this health information will **only** be shared with pertinent school staff.

_____ _____
Parent/Guardian Signature Date

Completed by Physician:

Medical History:

Medical Diagnosis	Chronic / Acute	Severity	Prognosis

Description of Medical Condition (symptoms, behaviors, etc.):

_____
_____
_____

Medication Regimen:

Medication Name	Dosage (Amount)	When to Use

Treatment Regimen / Emergency Services:

_____
_____
_____

Individual Considerations (Please indicate any special diet, physical activity limitations / adaptations, prosthetic devices, special procedures / interventions, and / or impact on school attendance):

_____
_____
_____

_____ _____
Physician Signature Date