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.):

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____

Medication Regimen:

Medication Name	Dosage (Amount)	When to Use

Treatment Regimen / Emergency Services:

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

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____ ____________________________________

Physician Signature Date