HARVESTCHRISTIANACADEMY
INDIVIDUAL HEALTH CARE PLAN

MEDICATION ADMINSTRATION

STUDENT NAME: _____**D.O.B:** _____**Grade:**_____

Health Condition: _____

Symptoms	**Treatment**

MEDICATION AND DOSAGE:

Give_____ Dose_____ Route_____ How Often_____

Give_____ Dose_____ Route_____ How Often_____

Give_____ Dose_____ Route_____ How Often_____

Physician Name: _____ Physician Signature: _____

Office Number: _____ Date_____

****PLEASE FILL OUT PAGE 2 ALSO******

INDIVIDUAL HEALTH CARE PLAN – Part 2

Individual Considerations:

Classroom:

O No restrictions
O Other_____

_____

Cafeteria:

O No restrictions
O Lunchroom supervisor should be alerted to the student's health condition
O Other_____

_____

Field Trip Procedures:

O No restrictions
• Certified staff member will review care plan prior to trip
• Parent/guardian should be advised of any planned field trips and allowed to accompany if possible
• Other_____

_____

Student Considerations:

• Student is able to recognize signs and symptoms of health condition O Yes O No
• Student knows how to manage the health condition in a school setting O Yes O No
• Other_____

_____

School Environment Considerations:

• _____

• _____

Parent/Guardian Authorization:

• I request this medication be administered as ordered by the student's licensed health care provider.
• I give Health Services staff permission to communicate with the health care provider about this medication.
• I agree that this medical information may be shared with school staff working with my child and 911 staff if needed.
• I assume responsibility for supplying medication to the school that will not expire during the course of its intended use. **Expired medication can not be administered!**
• Medication must be in the original prescription container with instructions as noted by above health care provider.
• In the event of an emergency, I give my permission for transport and treatment at the nearest medical facility

Parent/Guardian Signature **Date:**

Nurse Signature **Date:**