General Plan of Care

Name:	
Regular HCP ☐ 504 HCP ☐	Date:
School:	Grade:
Student Number:	Birth Date:
Health Concerns/Diagnosis:	

Allergies:	
Medications:	**Dose/Time:**
Emotional/behavioral concerns:	
Dietary concerns/restrictions:	
Health Action Plan:	
Parent Signature	**Date:**
M.D. Signature (or med. Authorization form)	**Date:**

Contact Information:

Parent/Guardian:	**Home phone:**
1._____	**Work**: **Cell**:_____
2_____	**Work**: **Cell**:_____

Home Address:	**Teacher**:
Emergency contact:	**Phone:**
Primary Care Physician:	**Phone:**
Speciality MD:	**Phone:**
School Nurse:	**Phone:**

Nurse to distribute copies.

Copies:

☐ Parent ☐ PE
☐ Teacher ☐ Transportation