Clayton County Public Schools
Individual Health Plan

School ____________________________

School Year ____________________ **Date** ____________________

Student Name: ______________________________Allergies __________ Date of Birth: __________

Teacher: ______________________________________ Grade Level: ________________

Parents/Guardian: ______________________________Home Phone: ____________________

Cell Phone (Mother): ______________________ Work Phone (Mother): ____________________

Cell Phone (Father): ______________________ Work Phone (Father): ____________________

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 Printed Name Physician Signature Date