Educational Service Center
of Medina County
"Stepping Up to Excellence"

* OTHER.

Student Photo ID

Confidential

INDIVIDUAL STUDENT HEALTHCARE PLAN

Student's Name:	**School/Grade:**
Date of Birth:	**Contact Teacher:**
Parent/Guardian Name: **Mom:**	**Phone (Family):** **Cell:**
Email Address:	
Address:	
Physician: **Dr.** **Phone:** **Fax:** **Dr.** **Phone:** **Fax:**	**Licensed School Nurse: Lori Hogue RN** **Phone: 330-723-6393 x118** **District Nurse:** **Phone:**
Additional Emergency contact:	

Health Condition: **Date:**

Medications:

This plan is subject to change, but <u>ONLY</u> with documentation from physician or physical therapy and meeting with parents and staff. This plan will be shared with all teachers, support staff and transportation that are involved with student's school day.

I am in agreement with this plan of care and understand it will be shared as needed with members of the school staff to safeguard and promote the health of the student listed above while at school. I will notify the school immediately if: 1) the health status of the student listed above changes, 2) we change physicians, or 3) there is a change or cancellation of the physician's orders.

Parent/Legal Guardian _____ Date _____

Parent/Legal Guardian _____ Date _____

School Nurse _____ Date _____

MEDICAL REVIEW

I have reviewed the attached Individual Health Care Plan (IHP) for _____ AND:

_____ I approve the IHP as written.
_____ I approve the IHP with the attached amendments.
_____ I do not approve of the IHP as written, and substitute orders are attached.

Physician _____ Date _____

<u>Other Recommendations</u>:

Description of Condition:

Goals:

Plan/Goal/Interventions: