School District of Iola-Scandinavia-Confidential

Health Services: General Health Care Plan

Students Name:	Date of Birth:
Grade:	School Year:
Bus student: (Circle one) YES NO	

1.Please give a brief description of your child's health condition:

_____

_____

_____

2. Date of last Medical Evaluation: _____

3. Does it require alterations in the school setting? Yes_____ No_____

If yes please clarify: _____

_____

4. Are there any restrictions or precautions? Yes_____ No_____

If yes please clarify: _____

_____

5. Does your child take medication at home for this condition? Yes_____ No_____

If yes, MEDICATION: _____

DOSE: _____

TIME given: _____

If your child requires medication to be given at school a Medication Authorization Form must be signed and accompany this form with both parent and doctor signature

Doctor(s) Treating Condition: _____ Phone: _____

Doctors Address: _____

Please fill out back of form…

Mother	Father	Other
Name:	Name:	Name:
Home Phone:	Home Phone:	Home Phone:
Cell Phone:	Cell Phone:	Cell Phone:
Work Phone:	Work Phone:	Work Phone:
E-mail Address:	E-mail Address:	E-mail Address:

Authorization is hereby granted to release this information to appropriate school personnel and classroom teacher to ensure safe management of your child's condition. If there are any questions or changes in this plan, please inform the School Nurse and/or office staff as soon as possible.

Parent/or legal guardian Signature: _____Date: _____

School Nurse Signature: _____ Date: _____