



General Health Care Plan

Name: _____

HEALTH CONCERNS/DIAGNOSIS:

ACTION PLAN:

List of student's medications: _____
(If medications are to be given at school please complete parent/doctor authorization form)

Dietary restrictions: _____

Please know that most school employees will be aware of student's health concerns and action plan for the safety of your child.

Parent Signature: _____ Date: _____

Physician Signature: _____ Date: _____