

INDIVIDUALIZED HEALTH CARE PLAN

NAME: _____ DOB: _____ SEX: ____ ALLERGIES: _____ PHYSICIAN _____		
RELEVANT DIAGNOSIS (ES): _____		
DIET: _____ MOBILITY: _____ EQUIPMENT: _____		
MEDICAL HISTORY: _____		
MEDICATION/TREATMENT: _____		
SIGNATURE: _____ (parent)	SIGNATURE: _____ (student)	SIGNATURE: _____ (School Nurse)

HEALTH CARE GOAL

DATE	HEALTH PROBLEM/ NURSING DIAGNOSIS	STUDENT OBJECTIVES	INTERVENTION AND RESPONSIBLE PERSON	EVALUATION AND TIMELINE

NAME: _____

DATE	HEALTH PROBLEM/ NURSING DIAGNOSIS	STUDENT OBJECTIVES	INTERVENTION AND RESPONSIBLE PERSON	EVALUATION AND TIMELINE

Adapted from Hartford Public Schools for use in Connecticut Department of Education Guidelines for Students with Special Health Care Needs.