

Health Care Plan (HCP) for: _____

SCHOOL YEAR _____

TO BE COMPLETED BY PARENT/GUARDIAN:

Student Name:		Allergies:	Birthdate:
School:	Teacher:	Grade:	Date:
Medications Taken at Home*			
Additional Information/Updates			

**If a child requires medication while at school, a separate School Medication Order Form must be completed and attached to this HCP*

Contact information		
School Nurse: Lisa Poggensee, RN 530-264-8866 lpoggensee@nevcocsa.org email/phone	Parent(s):	Physician:

_____ Description:	
Emergency Drills/Evacuation needs	
Field Trip Needs	1.

HEALTH CONCERNS AND PROCEDURES FOR MEDICAL ACTION WHILE AT SCHOOL

Observe This:	Do This:
1.	1.
1.	1.
1.	1.

I authorize the school nurse and/or other trained school personnel to assist my child in taking his/her medications and treatments, and I authorize the nurse to consult with the Health Care Provider about my child's medical needs as necessary while my child is at school. I understand it is my responsibility to provide all medication, supplies and equipment and understand that if my child carries his own medication I should provide extra to be kept in the office in case needed.

I will be provided with a copy of my child's completed Health Care Plan. I have read and agree with the information provided above. I understand and give my consent for this information to be shared with the student's school, transportation, and emergency personnel as deemed necessary to provide quality of care. This consent is valid for one school year and may be revoked at any time.

Parent Signature: _____ Date: _____

Reviewed By:

School Nurse: _____ Date: _____

Principal: _____ Date: _____