5141.21 Form 7

INDIVIDUALIZED HEALTH CARE PLAN

Name: _____ DOB: _____ Sex: ___ Allergies: _____ Physician: _____

Relevant Diagnosis(es):

_____

Diet: _____ Mobility: _____ Equipment: _____

Medical History:

_____

Medication/Treatment:

_____

Signature: _____ Signature: _____ Signature: _____

(Parent) (Student) (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.