SUMNER COUNTY SCHOOLS
INDIVIDUALIZED HEALTH PLAN-GENERIC

_____504
_____504 Referral
(Date:_____)
_____IEP

I. IDENTIFYING INFORMATION

Student's Name: _____ DOB: _____

School: _____ Grade/Teacher: _____ Bus#: _____

Address: _____

Parent/Guardian's Name: _____ Lives with? Yes No

Daytime#: _____ Cell# _____ Email: _____

Parent/Guardian's Name: _____ Lives with? Yes No

Daytime#: _____ Cell# _____ Email: _____

II. PHYSICIAN

Physician: _____ Office#: _____

Physician Address: _____ Fax#: _____

Hospital of Choice: _____

III. EMERGENCY CONTACT

Name: _____ Relationship: _____

Daytime#: _____ Cell#: _____

Name: _____ Relationship: _____

Daytime#: _____ Cell#: _____

IV. MEDICAL OVERVIEW

Medical Condition: _____ Date of Diagnosis: _____

Signs-Symptoms:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medications:

At School: _____ Time: _____

At Home: _____ Time: _____

Possible Side Effects: _____

Drug Allergies: _____

Procedures at School: _____

Special Diet: _____

Safety Concerns/Limitations/Considerations: _____

V. ACTIONS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

This IHP is for one school year. I, the parent/guardian of _____ (student's name) give consent to release the information contained in the IHP to all staff members who will care for my child or who may need to know this information to maintain my child's health and safety. I will notify the school nurse immediately if the health status changes, there is a change of physicians, or there is a change or discontinuation of medications or procedures. I agree to provide medical equipment, supplies, and medication as needed for the care of my child.

Parent/Guardian Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

Physician Signature: _____ Date: _____