Fulton County Schools
Where Students Come First

Student Health Services

Individual Health Care Plan

Student Name: _____ **Date of Birth:** _____

Teacher: _____ **Grade:** _____ **School:** _____

Parent/Guardian Information:

Mother's Name: _____
Home #: _____
Work #: _____
Mobile/Other: _____
Address: _____
Email: _____

Father's Name: _____
Home#: _____
Work #: _____
Mobile/Other: _____
Address: _____
Email: _____

Note: This student has a health condition of which the school system staff needs to be aware. The medical diagnosis, care during school hours, emergency care, and individual considerations are stated below:

Medical Diagnosis/Condition:

_____
_____
_____
_____

Action Plan for School:

_____
_____
_____
_____
_____

Medications (Dosage/Frequency):

_____
_____
_____

Individual Considerations:

_____
_____
_____
_____

I am the parent/guardian of _____ and request that the Individual Health Care Plan be utilized during school hours.

School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this Individual Health Care Plan authorizes Student Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Health Care Provider Signature: _____ **Date:** _____

Physician Name *(print)*/Phone Number: _____

Parent Signature: _____ **Date:** _____