Cc:
□ Teacher(s)
□ PE Teacher
Office use only

DOWNEY UNIFIED SCHOOL DISTRICT

INDIVIDUAL HEALTH CARE PLAN

School Year _____

Student's Name: _____ D.O.B./ID# _____ School/Grade: _____

Emergency Information:

Emergency contact: _____ Relationship _____

Home Number _____ Work Number _____ Cell Number _____

Physician's name: _____ Physician's Number _____

TO BE COMPLETED BY PHYSICIAN

This is a child with (medical diagnosis):

_____

Signs to watch for:

1. _____
2. _____
3. _____

Steps to be followed in an Emergency Situation:

1. _____
2. _____
3. _____

Special Directions or Limitations applying to the student while at school: (To be completed by Physician and Parent)

1. _____
2. _____
3. _____

Please Complete & Sign Next Page

DOWNEY UNIFIED SCHOOL DISTRICT

INDIVIDUAL HEALTH CARE PLAN

School Year _____

TO BE COMPLETED BY PHYSICIAN

ALL CURRENT MEDICATION(S):

MEDICATION TO BE GIVEN AT SCHOOL: (If Any):

Name of Medication	**Dosage**	**Dose Form** (HFA, Nebulizer, Tab, Liquid, Etc.)	**Time**

Is medication supply for **daily** administration necessary during school hours? **Yes** ☐ **No** ☐

List all additional Medications given at home:

Name of Medication	**Dosage**	**Dose Form** (HFA, Nebulizer, Tab, Liquid, Etc.)	**Time**

Is medication supply for use in the event of a "**DISASTER"** necessary for school use? **Yes** ☐ **No** ☐

If yes, please provide a 72-hour supply of medication in a properly labeled container. This supply is ONLY to be used in the event of a natural disaster.

_____

Parent/Guardian Signature & Date

_____

Physician Signature & Date

Office Stamp - REQUIRED

Rev 07/23