Date of Plan:_____

General
Individual Health Care Plan

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the staff of Shining Stars Learning Center.

Effective Dates: _____

Student's Name: _____

Date of Birth: _____

Date of Diagnosis: _____

Classroom_____

Teacher's Names: _____

Contact Information

Parent/Guardian: _____

Address: _____

_____

Telephone: Home _____ Work _____ Cell_____

Parent/Guardian: _____

Address: _____

_____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:

Name: _____

Address: _____

Telephone: _____ Emergency Number: _____

Other Emergency Contacts:

Name: _____

Relationship: _____

Telephone: Home _____ Work _____ Cell _____

Name: _____

Relationship: _____

Telephone: Home _____ Work _____ Cell _____

Notify parents/guardian or emergency contact in the following situations: _____

_____

Chronic medical condition:

Describe chronic condition:

Symptoms:

Medical treatment that may be necessary while child is in our care:

Potential side effects of that treatment

Potential consequences to the child's health if treatment is not administrated:

Signatures

This Individual Health Care Plan has been approved by:

_____ _____

Student's Physician/Health Care Provider (Required) Date

I give permission to the designated staff members of Shining Stars Learning Center for my child _____ to perform and carry out the

care tasks as outlined by this Individual Health Care Plan above. I also consent to the release of the information contained in this Individual Health Care Plan to all staff members and other adults who take part in the care of my child at Shining Stars Learning Center and who may need to know this information to maintain my child's health and safety.

Acknowledged and received by:

Parent/Guardian	Date
Parent/Guardian	Date