



To complete this form electronically,
it must be opened in *Adobe Reader!*

Blood Disorder Individual Health Care Plan

School year _____

Student legal last name _____ First name _____ MI _____

Birth date _____ School _____ Grade _____ Other ID# _____

Teacher _____ Transportation:
 Walker Self Transported Bus Rider Bus/Route Number _____

Parent/Guardian Information

Parent/Guardian _____ Primary phone _____

Work phone _____ Cell phone _____

Parent/Guardian _____ Primary phone _____

Work phone _____ Cell phone _____

Physician and Hospital Information

Physician Name _____ Phone _____

Preferred Hospital _____ Phone _____

Medical Information

Current Medications

--

Allergies

--

Rescue and Maintenance

--

Health Concern (Diagnosis)

History

--

Special Precautions

--

Emergency Intervention

Moderate Symptoms

Immediate Response

[Empty box for Moderate Symptoms]

[Empty box for Immediate Response]

Severe Symptoms

Immediate Response

[Empty box for Severe Symptoms]

Call 911
Notify Parent/Guardian
Notify School Nurse
Notify School Principal
Do not leave the student unattended

Report concerns to parent for physician follow up.

Emergency Contacts

Name _____	Phone _____	Relationship _____
Name _____	Phone _____	Relationship _____
Name _____	Phone _____	Relationship _____

Parent/Guardian Signature _____	Date _____
School Nurse Signature _____	Date _____
Physician Signature _____	Date _____

A copy of this plan will be kept in the school office and copies will be given to:

- Para educator
 Transportation
 Teacher
 PE Teacher
 Student Services
 Health Room
 Secretary-Principal

Other _____

CONFIDENTIAL INFORMATION - SHRED PRIOR TO DISCARDING