RESET FORM

Student's Picture

UTICA COMMUNITY SCHOOLS

GENERAL HEALTH CARE PLAN

DIAGNOSIS:_____

EFFECTIVE DATE:_____

Student's Name_____

DOB_____Grade_____Teacher_____

Reviewed by: _____(health care provider)
Signature Date

Acknowledged by: _____(parent/guardian)
Signature Date

Acknowledged by: _____(school rep.)
Signature Date

Contact Information

Parent #1 Name_____ Parent #2 Name_____

Parent/Guardian #1: Home_____Work_____Cell_____

Parent/Guardian #2: Home_____Work_____Cell_____

Student's Doctor/Health Care Provider_____ Phone_____

Other Contact_____Relationship_____Phone_____

Notify parent/guardian in the following situation: _____

Student Medical/Surgical History

_____

_____

_____

Symptoms Leading to Diagnosis/Typical Symptoms for Student

_____

_____

_____

_____

_____

Medications at School

Medication	Dose	Route	When to give

Home Medications

Medication	Dose	Route	When to give

Activity and Accommodations

___Notify parents for the following symptoms:_____

_____

Additional accommodations for school:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Transportation

UCS Transportation Medical & Emergency Form Completed? ___Yes ___No