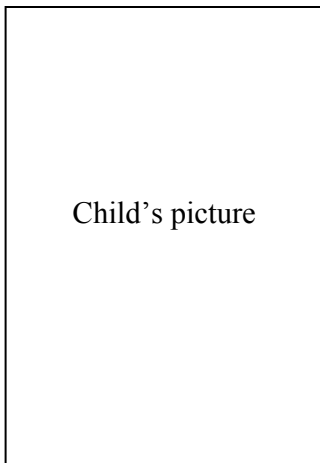


Utica Community Schools General Health Care Plan

DIAGNOSIS _____



Effective Date: _____
*To be completed by parents/health care team and reviewed with necessary school staff-
 copies should be kept in the student's classroom and school record.*

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: Telephone-Home _____ Work _____ Cell _____
 Parent/Guardian #2: Telephone-Home _____ Work _____ Cell _____
 Student's Doctor/Health Care Provider _____ Phone _____
 Other Emergency Contact _____ Relationship _____ Phone _____
 Notify parent/guardian in the following situations: _____

◆ Diagnosis

◆ MEDICATIONS TO BE GIVEN AT SCHOOL

| Medication | Dose/Route | When to use |
|------------|------------|-------------|
| | | |
| | | |

Authorization for medication form on file

◆ CONDITION

Description of condition & Specific Restrictions:

◆ **IF SYMPTOMS OCCUR**

- 1.
- 2.
- 3.

◆ **TRANSPORTATION**

| | | |
|---|-----|----|
| Special Needs Medical Information Form Completes? | Yes | No |
| Additional medication/supplies needed for bus? | Yes | No |