Utica Community Schools
General Health Care Plan
DIAGNOSIS_____

Child's picture

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