DISTRICT ADMINISTRATION OFFICE
W156N8480 PILGRIM RD
MENOMONEE FALLS, WI 53051
262.255.8440
Website: sdfm.schoolfusion.us

HEALTH CARE PLAN IN THE SCHOOL SETTING

School Year: ______________________

Student's Name: ____ School: ______________

Date of Birth: ______________________ Gender: ______________ Grade: __________________

Parent/Guardian's Name: ____

Mailing Address: ____

Home Phone: _______________________________ Work Number: _________________________

Cell Phone: _________________________________

Physician: ______________________Physician's Number: _______________ Fax:_____________

Allergies to: ____

Brief description of health problem: ____

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____

____

Early indicators for interventions:

____

____

Action to be taken:

____

____

Late indicators for staff interventions:

____

____

Action to be taken:

____

____

Medication – (If medication needs to be taken at school please fill out **Request for Medication to be Administered to a Student during School Hours** form.)

Name	Dosage	Possible side effects

Specific actions to follow in addition to above:

Activity limitations/restrictions:
____

____

Precautions:
____

____

Special dietary needs:
____

____

Psychological support:
____

____

Other:
____

____

This information may be shared with all appropriate staff

____ ____________________________
Student's Signature Date

____ ____________________________
Parent/Guardian's Signature Date

____ ____________________________
Health Care Provider's Signature Date

CARE PLAN REVIEWED WITH SCHOOL PERSONNEL

School Representative Signature(s)	Date