INDIVIDUALIZED HEALTH CARE PLAN

NAME:_____ DOB:_____ SEX:_____ALLERGIES:_____ PHYSICIAN:_____

RELEVANT DIAGNOSIS:_____

DIET:_____MOBILITY:_____EQUIPMENT:_____

MEDICAL HISTORY:_____

MEDICATION/TREATMENT:_____

SIGNATURE:_____SIGNATURE:_____SIGNATURE:_____
(Parent) (Student) (Nurse)

LIASON WITH FAMILY:_____ DATES OF MEDICAL ORDERS: _____/_____/_____/_____

| DATE | HEALTH PROBLEM/NURSING DIAGNOSIS | STUDENT GOALS | INTERVENTION AND RESPONSIBLE PERSON | EVALUATION AND TIMELINE |
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