Print Form

OWOSSO PUBLIC SCHOOLS | SCHOOL HEALTH SERVICES

HEALTH CARE PLAN *

Student's Name _____Date of Birth _____

Teacher _____Grade _____

Parent/Guardian_____

Day time numbers where you can be reached _____

_____

If your child has a significant health condition, please fill out this form and return to the office. If not, please disregard.

Emergency Contact _____
(Name) (Relationship) (Phone Number)

Doctor's Name _____ Phone Number _____

Health Condition _____

How does this affect your child at school? _____

_____

Are there any activity restrictions? _____Yes _____No

Please explain: _____

_____

Does your child take medication for this condition? _____ Yes _____ No
Please list medications taken for this condition. Indicate medication needed at school.**

Name	Amount	Time

List signs and symptoms of an emergency: _____
_____

Actions to take in an emergency: _____
_____

I understand that this information will be shared with school staff, as needed.
Reviewed by:
Parent/Guardian _____ Date_____

Rev. 3/08
*Not every student will need to return this sheet. If your child has a significant health concern, however, please return this form to school as soon as possible each fall.
**A separate medication form will also be needed for students to take medication at school.