

Student's Health Care Plan

Name			Date	
DOB	Age	M <input type="checkbox"/> F <input type="checkbox"/>	Class Teacher (Primary) Or Home Teacher (Middle or Secondary)	
School			Year Level	
Parents /Guardians			Address	
Phone Contact		Health Care Team		

BACKGROUND	
ASSESSMENT SUMMARY	
AREAS OF CONCERN	
ACTIONS TO BE TAKEN	
RECOMMENDATIONS	
Signature of Parent / Guardian	Date
Signature of Principal	Date
Signature of Medication Administration Officer	Date