**Student’s Health Care Plan**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name | | | | | | Date |
| DOB | Age | M F | | | Class Teacher (Primary)  Or Home Teacher (Middle or Secondary) | |
| School | | | | | | Year Level |
| Parents /Guardians | | | | Address | | |
| Phone Contact | | | Health Care Team | | | |

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| --- |
| 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 |