**Student’s Health Care Plan**

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| --- | --- |
| 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 |