INDIVIDUALIZED HEALTH PLAN

Independent School District 279

Name _____ DOB _____ ID# _____

Address _____

Parent/Guardian _____ H _____ W _____

C _____ P _____

Parent/Guardian _____ H _____ W _____

C _____ P _____

Physician _____ Telephone _____

Physician _____ Telephone _____

Hospital Preference _____

Medical Diagnosis

IEP yes ☐ no ☐ Last Medical Update/Physical Exam _____

504 Plan yes ☐ no ☐ Allergies _____

Student Emergency Plan yes ☐ no ☐ Vision/Hearing _____

Medication

Pertinent medical history/assessment findings:

Student Health Problems/Plan	
1.	a.
2.	a.
3.	a.
4.	a.
5.	a.
6.	a.
7.	a.
8.	a.
9.	a.
10.	a.
11.	a.