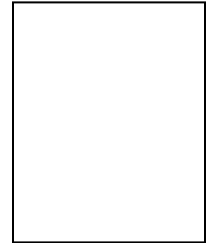


**Abington Heights School District
200 East Grove Street
Clarks Summit, PA 18411**

Individualized Health Care Plan

Health Care Plan for Period _____ to _____



Student's Name: _____ **Birthdate:** _____

Teacher: _____ **Grade/Team:** _____ **Age:** _____

Contact Information

Parent's Name: _____

Parent's Address: _____

Parent's Home Telephone: _____

Mother's Work # _____ **Mother's Cell #** _____

Father's Work # _____ **Father's Cell #** _____

Physician: _____ **Telephone:** _____

Hospital: _____

Medical Overview

Medical Condition: _____

Allergies (List All): _____

Medications (List All): _____

Brief Medical History: _____

Health Care Action Plan

***Health Care Procedure/Treatment:**

Classroom School Modifications/Limitations: _____

Parent Signature(s) _____ **Date** _____

_____ **Date** _____

Physician Signature: _____ **Date** _____

***We (I) agree to provide the following, if any: medical equipment and supplies, medication, and dietary supplements.**

Date review: _____