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: _____