

# SCHOOL INDIVIDUALIZED HEALTH CARE PLAN

Student \_\_\_\_\_

Effective Date \_\_\_\_\_

Parent \_\_\_\_\_

School \_\_\_\_\_

Physician \_\_\_\_\_

Nurse \_\_\_\_\_

\_\_\_\_\_ Special Education

\_\_\_\_\_ Section 504

\_\_\_\_\_ General Education

## 1. Brief Description of Condition:

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## 2. Concerns:

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## 3. Goal:

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## 4. Intervention and Procedures:

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**5. Necessary Staff Training:**

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I have read and approve of the above health care plan for: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Parent

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Nurse who provides  
services in the school