Christian Liberty Academy
502 W. Euclid Avenue, Arlington Heights, Illinois 60004
(847) 259-4444 FAX (847) 385-2062

INDIVIDUAL HEALTH CARE PLAN

(includes any health condition that requires accommodation at school i.e. Scoliosis, Hemophilia, Hearing Deficits.)

STUDENT NAME: ______________________________ D.O.B.____________ GRADE: ________

Health Condition ____

Date of last exam for this condition: _____________ Age at which health concern diagnosed: ____________

Symptom	Treatment

MEDICATION ORDERS:

To be completed by the physician

Name of Mediation	Dose:	Route:	Frequency

______________________________________ ________________________________

Signature of Health Care Provider with Prescriptive Authority License Number of Health Care Provider

______________________________ ______________________________ Dated: __________

Printed Name of Health Care Provider Phone Number

INDIVIDUAL HEALTH CARE PLAN – Part 2 Name of Student:________________________________

TO BE COMPLETED BY PARENT/GUARDIAN:

Individual Considerations:

Classroom:
☐ No restrictions
☐ Other____
____

Cafeteria:
☐ No restrictions
☐ Lunchroom supervisor should be alerted to the student's health condition
☐ Other____
____

Field Trip Procedures:
☐ No restrictions
☐ Certified staff member will review care plan prior to trip
☐Parent/guardian should be advised of any planned field trips and allowed to accompany if possible
☐Other____
____

Student Considerations:
• Student is able to recognize signs and symptoms of health condition ☐ Yes ☐ No
• Student knows how to manage the health condition in a school setting ☐ Yes ☐ No
☐Other____
____

School Environment Considerations:
• ____
• ____

Parent/Guardian Authorization:

- I request this medication be administered as ordered by the student's licensed health care provider.
- I give Health Services staff permission to communicate with the health care provider about this medication.
- I agree that this medical information may be shared with school staff working with my child and 911 staff if
- needed.
- I assume responsibility for supplying medication to the school that will not expire during the course of its
- intended use. Expired medication cannot be administered!
- Medication must be in the original prescription container with instructions as noted by above health care
- provider.
- In the event of an emergency, I give my permission for transport and treatment at the nearest medical facility

I give permission for this information to be shared with adults at Christian Liberty Academy on a need to know basis. *This health care plan will be in effect for the current school year. I understand that it is my responsibility to notify the Nurse's Office whenever there is a change in my child's health status or care.*

____ Dated: ____________________

Parent/Guardian Signature