Cc:
☐ Teacher(s)
☐ PE Teacher
Office use only

DOWNEY UNIFIED SCHOOL DISTRICT

INDIVIDUAL HEALTH CARE PLAN

School Year ___________________

Student's Name: _______________________________ D.O.B./ID# ___________________ School/Grade: ________________

Emergency Information:

Emergency contact: ____ Relationship _____________________

Home Number _______________________ Work Number ____________________ Cell Number ____________________

Physician's name: ____ Physician's Number ____________________

TO BE COMPLETED BY PHYSICIAN

This is a child with (medical diagnosis):

____

Signs to watch for:

1. ____
2. ____
3. ____

Steps to be followed in an Emergency Situation:

1. ____
2. ____
3. ____

Special Directions or Limitations applying to the student while at school: (To be completed by Physician and Parent)

1. ____
2. ____
3. ____

Please Complete & Sign Next Page

Approved: Assistant Superintendent

Rev 05/13

DOWNEY UNIFIED SCHOOL DISTRICT

INDIVIDUAL HEALTH CARE PLAN

School Year ___________________

TO BE COMPLETED BY PHYSICIAN

ALL CURRENT MEDICATION(S)

MEDICATION TO BE GIVEN AT SCHOOL (If Any):

Name of Medication	**Dosage**	**Dose Form** (HFA, Nebulizer, Tab, Liquid, Etc.)	**Time**

Is medication supply for **daily** administration necessary during school hours? **Yes** ☐ **No** ☐

LIST ALL MEDICATIONS **GIVEN AT HOME**

Name of Medication	**Dosage**	**Dose Form** (HFA, Nebulizer, Tab, Liquid, Etc.)	**Time**

Is medication supply for use in the event of a "**DISASTER"** necessary for school use? **Yes** ☐ **No** ☐

If yes, please provide a 72-hour supply of medication in a properly labeled container. This supply is ONLY to be used in the event of a natural disaster.

Parent/Guardian Signature **Date** **Physician Signature** **Date**