St. Vincent de Paul School
206 E Chestnut St. Mt. Vernon, Ohio 43050 740-393-3611 www.saintvdpschool.org

Individualized Health Care Plan

For School Year 20 _____ - 20_____

Student Name _____

Date of Birth_____ Grade _____

Diagnosis _____

Information about diagnosis:

Accommodations in the school setting:

Symptoms to be aware of:

Emergency Action Plan:

Parent Signature _____ Date _____

Principal's Signature _____

Office Personnel Signature _____

Office Personnel Signature _____

Office Personnel Signature _____

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SCHOOL REQUEST FORM FOR ADMINISTRATION OF MEDICATION PARENT & PHYSICIAN AUTHORIZATION

STUDENT'S NAME _____ GRADE _____

STUDENT'S ADDRESS _____

PHYSICIAN'S ADDRESS _____

PHYSICIAN'S TELEPHONE NUMBER _____ EMERGENCY NUMBER _____

REASONS FOR EMERGENCY MEDICATION DURING SCHOOL HOURS _____

_____

DATE MEDICATION TO BEGIN _____ DATE MEDICATION TO END _____

APPROXIMATE TIMES FOR ADMINISTERING MEDICATION _____

STUDENT MAY SELF-ADMINISTER MEDICATION UNDER SUPERVISION OF SCHOOL EMPLOYEES? YES☐ NO ☐

MEDICATION NAME _____ DOSAGE (MG) _____

ROUTE _____

SPECIFIC INSTRUCTION FOR STORING THE MEDICATION _____

POSSIBLE REACTIONS THAT SHOULD BE REPORTED TO PHYSICIAN _____

_____

MEDICATION STORED IN OFFICE _____ WITH THE STUDENT _____ ☐

I, _____, hereby state that I am a duly qualified and licensed medical practitioner in the State of Ohio, and that the above mentioned student is under my care. I request that the medication be administered during school hours by the student, as indicated, or if not, then by approved employees who have volunteered to do so.

_____ _____

Date Physicians Signature

I give permission to school employees to administer the above medication and to not hold them liable for damages or injuries resulting directly or indirectly from presence of medication in the school or its use by the student. Also, I will notify the school if there is a change in physician's order of dosage or change in medication.

_____ _____

Date Parent or Guardian

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