SCHOOL DISTRICT OF THORP
Student Health Services

School Year _____ **INDIVIDUAL ACTION PLAN**

Student Name _____

Date of Birth _____ Grade _____ Grad Year _____

School _____ Teacher/HR _____

PARENT / GUARDIAN EMERGENCY CONTACT INFORMATION:

Please provide phone numbers in order of where we can reach you during the school day in case of emergency.

Phone 1. _____ H/C/W Name/Relationship _____

Phone 2. _____ H/C/W Name/Relationship _____

Phone 3. _____ H/C/W Name/Relationship _____

Phone 4. _____ H/C/W Name/Relationship _____

Email for Health Plan updates:

Condition: _____

(Please Provide Description)

Physician student sees for Condition _____ Phone _____

Receiving Medical Treatment: Yes____ No____

Medications given at **home** for this condition (name, dose, frequency)

_____

_____

Medications given at **school** for this condition (name, dose, frequency)

_____

_____

NOTE: Parents are responsible for providing medication in original container to be given at school. Complete a Medication Authorization Form signed annually by a parent and health care provider.

Likelihood and Frequency of Exacerbation During School Hours –Please Describe: _____

_____

_____

Describe First Aid Procedures (if any): _____

_____

_____

Please List Any Other Chronic Health Problems:_____

_____

PLEASE COMPLETE AND SIGN NEXT PAGE →

Student Name _____

Please specify any special accommodations or concerns related to your child's health condition while at school and describe them briefly: (i.e., dietary, educational, behavior, seating, etc.)

_____

_____

_____

_____

Physical Education and Classroom Precautions
(Activity restrictions specified by health care provider need to be in writing and signed)

_____

_____

_____

Dietary Precautions: _____

_____

Sport Precautions: _____

_____

Recess Precautions: _____

_____

Special Considerations for Field Trips: _____

_____

Other relevant information related to the health condition or student's health history:

_____

_____

_____

_____

This plan and medication will be used in case of emergency and accompany student off school property. This information may be shared with the classroom teacher(s), administrators, aides, bus driver, and other appropriate school personnel with a need to know.

Parent/Guardian Signature: _____ Date _____

Health Care Provider Signature: _____ Date _____

School Nurse: _____ Anna Lisiecki, BSN, RN