

**INDIVIDUALIZED HEALTHCARE PLAN FOR GENERAL OR NONSPECIFIC
CONDITION OR DISEASE
2021-2022 SCHOOL YEAR**

To be completed by the Parent:

Student Name: _____ Grade: _____

Condition or Disease: _____

| EMERGENCY CONTACTS | OTHER EMERGENCY CONTACTS |
|------------------------|--------------------------|
| PARENT/GUARDIAN: _____ | NAME: _____ |
| PHONE: _____ | PHONE: _____ |
| DOCTOR: _____ | NAME: _____ |
| PHONE: _____ | PHONE: _____ |

_____ (Student Name) has _____ as mentioned above and in the Individualized Health Care Plan from the physician. I have provided to the school the physician's medication permission and instructions. I am requesting these instructions be carried out by the school. I have reviewed with my child about his/her condition or disease and to tell an adult immediately if they have any difficulties. I will provide the medication with a proper pharmacy label and be aware of the expiration date to replace the medication. I hereby request the medication specified by the physician be given to the above named student, and it may be administered by medical or non-medical personnel. I understand 911 may be contacted if concerns arise.

Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Galveston-Houston, its servants, agents, any employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston-Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent Signature: _____ Date: _____

To be completed by School:

School Nurse/Health Coordinator Signature: _____ Date: _____

Principal Signature: _____ Date: _____

Before & After Program Coordinator Signature: _____ Date: _____
(If applicable)

Teacher notification provided by: _____ Date: _____

➤ School staff may be notified of the student's health condition and the treatment plan in case of an emergency.

INDIVIDUALIZED HEALTHCARE PLAN FOR GENERAL OR NONSPECIFIC CONDITION OR DISEASE 2021-2022 SCHOOL YEAR

To be completed by the Physician:

Students Name: _____ D.O.B.: _____

What is the condition or disease? _____

How can this affect learning? _____

How does this affect the student in school (example: fainting, tiredness, etc.)? _____

Are there any medications or treatments needed at school?

| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|---------------------------------|-----------------------------|
| Type of Medication <input type="checkbox"/> Prescription <input type="checkbox"/> Non-Prescription | | Name of Medication and Strength | |
| Date to Begin Medication | Date to End Medication | Time to be Given | Amount to be Given (Dosage) |
| For PRN state the Frequency (time between dosages of medication and maximum number in a school day) | | | |
| Reason medication being given | | | |
| Form of Medication <input type="checkbox"/> Tablet <input type="checkbox"/> Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhalant <input type="checkbox"/> Injection <input type="checkbox"/> Other _____ | | | Route (ex: oral, nasal) |

| | | | |
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| Type of Medication <input type="checkbox"/> Prescription <input type="checkbox"/> Non-Prescription | | Name of Medication and Strength | |
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| Reason medication being given | | | |
| Form of Medication <input type="checkbox"/> Tablet <input type="checkbox"/> Capsule <input type="checkbox"/> Liquid <input type="checkbox"/> Inhalant <input type="checkbox"/> Injection <input type="checkbox"/> Other _____ | | | Route (ex: oral, nasal) |

What care is necessary for the student while the student is in school or attending school-related activities? _____

Any school restrictions? _____

What problems or emergencies can arise? _____

What is to be done by the school? _____

What is the student's responsibility? _____

Any other information the school should know about the care of the student? (Please attach any documents if necessary) _____

Physician signature: _____ **Phone:** _____ **Date:** _____