

CENTRAL VALLEY SCHOOL DISTRICT #356
19307 E. Cataldo, Spokane Valley, WA 99016

INDIVIDUALIZED HEALTH CARE PLAN / SECTION 504 PLAN

I. IDENTIFYING INFORMATION	
Student's Name	School
Birthdate	Teacher
Age	Grade
CONTACTS	
PARENTS/GUARDIANS	
Mother's Name _____	
Mother's Address _____	
Mother's Home Telephone _____ Work Telephone _____ Cell/Pager _____	
Father's Name _____	
Father's Address _____	
Father's Home Telephone _____ Work Telephone _____ Cell/Pager _____	
PHYSICIAN	
Physician _____	
Physician Address _____ Telephone _____	
HOSPITAL	
Hospital preference _____	
SCHOOL	
School _____ Telephone _____	
School Nurse _____ Cell/Pager _____	
II. MEDICAL OVERVIEW	
Medical Condition _____ Any Known Allergies _____	
Medications _____	
Possible Side Effects _____	
Necessary Health Care Procedures at School _____	

Health Care Plan for Period _____ to _____	

III. OTHER IMPORTANT INFORMATION

Nurse presence required (minimum):

- full-time with student full-time in building weekly annually

IV. BACKGROUND INFORMATION/NURSING ASSESSMENT

Brief Medical History

Check if additional information is attached

Specific Health Care Needs

Check if additional information is attached

Social/Emotional Concerns

Check if additional information is attached

Academic Achievement

Check if additional information is attached

V. HEALTH CARE ACTION PLAN

Attach physician's order and other standards for care.

Procedures and Interventions (student specific)

Procedure	Administered by	Equipment	Maintained by	Auth/trained by
1.				
2.				
3.				

V.HEALTH CARE ACTION PLAN (cont.)

Medications

Check if medication given at school. Attach copy of Medication Authorization

Diet

Check if additional information is attached

Transportation

Check if additional information is attached

Classroom School Modifications (including adapted PE)

Check if additional information is attached

Equipment – List necessary equipment/supplies

Provided
by Parent

Provided
by District

1.

2.

3.

4.

None Required

Safety Measures

Check if additional information is attached

Emergency Care Plan Attached

Transportation Plan Attached

Training Plan Attached

Substitute/Backup Staff (when primary staff not available)

Possible Problems to be Expected

Training

VI. HEALTH CARE PLAN REVIEW

Next review date of Health Care Plan _____

VII. DOCUMENTATION OF PARTICIPATION

We have participated in the development of the Health Care Plan and agree with its contents.

Signature

Date

Title

Principal or Designee

Teacher

School Nurse

VIII. PARENT AUTHORIZATION FOR SPECIAL HEALTH SERVICES

We (I), the undersigned, who are parents/guardians of _____
(Student Name) (Birthdate)
request and approve the attached Individualized Health Care / Section 504 Plan

We (I) will notify the school immediate if the health status of _____
(Student Name)
changes, we change physicians, or there is a change or cancellation of the procedure.

We (I) agree to provide the following, if any needed: medical equipment and supplies, medication, dietary supplements.

Parent Signature

Parent Signature

Date

Date