GENESEE COUNTY School Health Services

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HEALTH CARE PLAN

Student's Name _____ Date of Birth _____
Teacher _____ Grade _____
Parent/Guardian _____ Phone Number _____
Work Number _____ Cell Number _____ Pager Number _____
Emergency Contact _____
(Name) (Relationship) (Phone Number)
Doctor's Name _____ Phone Number _____

Health Condition _____
How does this affect your child at school? _____
_____
_____

Are there any restrictions? _____ Yes _____ No
Please explain _____
_____

Name	Amount	Time

List signs and symptoms of an emergency _____
_____
_____

Actions to take in an emergency _____
_____
_____

I understand that this information will be shared with school staff responsible for the care and management of the above health concern for my child.

Reviewed by:

Parent/Guardian _____ Date _____
School Representative _____ Date _____
Physician _____ Date _____

GISD/SHS/8-02
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