



Medford School District 549C

Individualized Healthcare Plan- \_\_\_\_\_

School Year \_\_\_\_\_

School \_\_\_\_\_

Bus/Walk \_\_\_\_\_

Student \_\_\_\_\_ Student ID: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade: \_\_\_\_\_  
First Last

Parent(s)/Guardian(s): \_\_\_\_\_ Phone \_\_\_\_\_

Parent(s)/Guardian(s): \_\_\_\_\_ Phone \_\_\_\_\_

Health History:

Medication(s): \_\_\_\_\_

Allergies to medication: \_\_\_\_\_

**HEALTH CONCERNS:**

Symptom	Plan/ Action needed	Contact Parent? Yes/ No

An up-to-date school district medication administration permission form signed by parent/guardian must be on file in the school office for all medications that are to be administered at school.

I give permission to the school nurse and other properly trained and authorized staff members of the Medford 549C School District to perform and carry out the tasks as outlined by my child's Individualized Healthcare Plan. I also consent to the release of the information pertaining to my child's medical condition to the staff members who have custodial care and those who may need to know this information to maintain my child's health and safety during the school day. If the health condition listed has changed I will inform my child's school or school nurse. This health care plan will be in effect while my student attends MSD.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please return this completed form to the office at your child's school.**