Sample
(SCHOOL NAME)
INDIVIDUAL HEALTH PLAN

DATE: ______________________ **PHYSICIAN**: ______________________________________
STUDENT: **DATE OF BIRTH:**_________________________ **ALLERGIES**: _____________________
RELEVANT DIAGNOSIS: ____

SECONDARY HEALTH ISSUE: ____
DIET: **MOBILITY**: **EQUIPMENT**:
____________________________ ________________________________ __________________________

MEDICAL HISTORY:
____

MEDICATIONS: ____
TREATMENTS: ____

SIGNATURE: ____

HEALTH PROBLEM	GOAL	PLAN OF ACTION	PERSON RESPONSIBLE/LOC
#1	#1		

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