

WRIGHTSTOWN COMMUNITY SCHOOL DISTRICT  
GENERAL INDIVIDUAL HEALTH PLAN/EMERGENCY ACTION PLAN

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Contact Information

Parent/Guardian (1): \_\_\_\_\_ email: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Parents/Guardian (2) Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialty MD: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Action Plan

Health Concerns/Diagnosis: \_\_\_\_\_

Please give a brief history of your child's medical condition including duration of the condition, any limitations in daily activities, etc.: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Special considerations at school related to medical condition: \_\_\_\_\_

\_\_\_\_\_

Other health concerns: \_\_\_\_\_

Emergency Care Plan

Symptoms of an emergency may include any/all of these: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Steps to follow for an emergency: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Treatment or Medication in case of an emergency: \_\_\_\_\_

\_\_\_\_\_

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Routine medications: \_\_\_\_\_ Dose/Time: \_\_\_\_\_

Medication side effects to observe for: \_\_\_\_\_

Allergies: \_\_\_\_\_

- I authorize to release this information to appropriate school or bus personnel and classroom teachers.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*This plan will be reviewed at least annually or when the parent notifies the school of a change in health needs.