HEALTH ASSESSMENT/MEDICAL PLAN

IDENTIFYING INFORMATION:

Student Name:_____Student ID:_____Date of Birth:_____
Address:
Parent(s)/Guardian(s):
Phone: Home:
Emergency Phone Numbers:
School Attending: **Classroom Teacher:**
Home School District:

MEDICAL INFORMATION:

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Medical Condition/Diagnosis:

Primary Care Physician: **Phone Number:** **Fax#:**
Hospital Phone Number (911) or: **Medical Insurance (optional):**
Other Health Care Providers/Agencies Involved (with):

Name: **Phone:**
Address: . **Fax#:**

Name: **Phone:**
Address: . **Fax#:**

Name: **Phone:**
Address: . **Fax#:**

Name: **Phone:**
Address: . **Fax#:**

AREA OF CONCERN **INDICATORS (circle one)**

MEDICATION(s) **YES** **NO**

__Administered at school
__Route of administration

Comments/Name and Dosage of Medication:

***Medications and medication orders will be kept in a locked cabinet in school nurse=s office**

NURSING TREATMENTS **YES** **NO**

__Administered at school

Comments/Type of treatment(s):

MOBILITY **YES** **NO**

___Wheelchair
__Manual
__Power
___Restraints/safety equipment
___Unstable ambulation

Comments:

COMMUNICATION **YES** **NO**

___Student=s speech is difficult to understand
___Non-verbal
__Signs/gestures
__Other (sounds)

Comments:

SEIZURES **YES** **NO**

__Currently
__Controlled with medication

Comments:

RESPIRATORY **YES** **NO**

__Mechanical ventilation required __Home __School
__Suctioning required __Home __School
__Oxygen required __Home __ School
_Asthma

Comments:

AREA OF CONCERN	**INDICATORS (circle one)**	
ALLERGIES	**YES**	**NO**
__Life threatening (i.e., peanuts, bee sting)		
Comments:		
MEDICAL EMERGENCIES IN THE PAST TWO YEARS	**YES**	**NO**
Comments:		
TOILETING	**YES**	**NO**
__Not toilet trained		
__Catheterization required		
___Clean intermittent catheterization		
___Sterile		
__Diapers/Attends/Clothing required		
FEEDING	**YES**	**NO**
___Special dietary needs		
___Tube feeding		
Comments/Procedure:		
ATTENDANCE CONCERNS:	**YES**	**NO**
__Health related		
___Behavior related		
IMMUNIZATIONS	**YES**	**NO**
___Up to date		
__Medical exemption		
___In possession of documentation		
CONTACT WITH AGENCIES	**YES**	**NO**
___Medical facilities (clinics, hospitals)		
___Behavior/counseling		
__Social Services		
Comments:		

AREA OF CONCERN **INDICATORS (circle one)**

SPECIAL PROGRAM CONSIDERATIONS: **YES** **NO**

___OT (needs prescription from M.D.)
___PT (needs prescription from M.D.)
___Vision
___Hearing
____Nursing Service
____Speech/Language
___Other Social Work:

Comments:

REVIEW MEDICAL PLAN WHEN:

X	There are significant health changes
X	There is a change of school placement
X	At least once a year
X	Per request of parent(s) or school

ROLES AND RESPONSIBILITIES:

Private Duty Nurse/Agency Nurse:

Community Health Nurse:

Nursing Care Agency (Supervisor):

School Nurse:

Family:

Classroom Teacher

Administrator:

Transportation (if applicable)

NAME/TITLE OF INDIVIDUAL COMPLETING THIS FORM:

Office phone:
Cell Phone: **Fax #:**

_____ **Date Completed**: _____
Signature

Reviewed plan with , classroom teacher and classroom Staff: **Date:**

Reviewed plan with parent(s**):** **Date:**

cc: