KENILWORTH PUBLIC SCHOOL DISTRICT
STUDENT HEALTH CARE PLAN

Student Name____ Birth Date_________________ Male or Female
School ____ Grade ________________

Primary Physician's Name ____ Phone _________________

Specialty Physician's Name____ Phone __________________

Emergency Contact #1 Name____ Relationship__________________

Phone____ Phone____

Emergency Contact #2 Name____ Relationship___________________

Phone____ Phone____

Preferred Hospital:____

For Emergency Transport Call 9-1-1

Type of Health Condition:

Heart Condition	Kidney Disease	Muscular Disorders
High Blood Pressure	Crohn's Disease	Anxiety
Low Blood Pressure	Ulcerative Colitis	Depression
Bleeding Disorder	Irritable Bowel Syndrome	Migraines/Headaches
Gastrointestinal Disorder	Hydrocephalus/Shunt	Other:
Feeding Tube	Bone/Joint Condition	

Please note-a specialized care plan form is available for students with Asthma, Severe Allergic Reactions, Seizure Disorders, Bleeding Disorders, and Diabetes. Please use these specialized forms available on the district's website, from your District Nurse.

Description of Health Condition: ____
____
____
____

Triggers related to Health Conditions: ____
____
____
____

Daily Medications

Medication	Where?		When?	
	Home	School	Home	School
	Home	School	Home	School
	Home	School	Home	School

Emergency Medications (for use as needed)

Medication	Where is it kept?		When to use?
	Health Room	Student	
	Health Room	Student	
	Health Room	Student	

←---------------OVER---------------→

Early Indicators & Staff Intervention

Indicators:	Action to be taken by staff:	Contact Parent
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO
		YES NO

EMERGENCY –Late Indicators for Staff Intervention

EMERGENCY – Actions to be taken when Late Indicators are present:

1) Keep calm.
2) Call 9-1-1 for transport to a medical facility.
3) While waiting for medical personnel to arrive, monitor for respirations and pulse as CPR may be required.
4) **CALL PARENT** to make them aware of the condition of their child and that 9-1-1 has been called for transport to a medical facility.

Further needs in regarding this student's health condition(s):

Activity limitations/restrictions: ____

____

Academic Concerns: ____

____

Precautions: ____

____

____

Special Dietary Needs: ____

____

____

Psychological Support Needs: ____

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This Student Health Care Plan has been completed and reviewed by physician, student, parent, and District Nurse. The information will be provided to administrators, teachers, and staff to allow for awareness in providing the best care for the student.

This Student Health Care Plan, emergency medications, and the student's Emergency Card is to accompany the student on school Field Trips to allow for the appropriate response when outside of the school building during school hours.

Physician Signature ____ Date ________________________

Student Signature____ Date ________________________

Parent Signature____ Date _________________________

District Nurse Signature ____ Date _________________________