POUDRE SCHOOL DISTRICT

Pupil Services

☐ Original filed in Cum
Date _____ By _____ initial

Health Care Action Plan—Basic

Please return form to: _____ School _____ Fax

Name: _____ DOB: _____

ID#: _____ Grade: _____ Parent/Guardian: _____

Address: _____ City/State/Zip: _____

Home phone: _____ Work phone: (mother) _____ (father) _____

Emergency contact: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Specialist: _____ Phone: _____

Description of illness or condition: _____

_____

_____

Medications/dose/time: _____

_____

Physical restrictions: _____

_____

Concerns/urgent action(s): _____

_____

Comments: _____

_____

_____

_____

I give permission for the information contained on this HCAP to be shared with adults in the school setting that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one year or until the health status or physician's orders change. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care.

School Nurse	Date	Parent/Guardian	Date	Health Care Provider	Date

Rev. 5/1/03