Health Care Action Plan - Basic

Please return form to: Resurrection Christian School Fax: 970 647 7385

Student Name _____ DOB _____ Grade _____

Address _____ City/State/Zip _____

Parent/Guardian _____ Home Phone _____

Work Phone (mother) _____ (father) _____

Emergency Contact _____ Phone _____

Primary Care Provider _____ Phone _____

Specialist _____ Phone _____

Brief Description of Illness or Condition

Medication/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 settings that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one school year or until the health status of 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.

Health Care Provider (MD/DO/NP/PA) Date Parent/Guardian Date School Nurse Date