Individual Health Plan (IHP)

Child's Name:			Date:
Birth Date:		Class:	
Health Concerns/Diagnosis:		Parents/Guardians:	
Health Action Plan:			
Medications:	Dose/Time:		
Allergies:			
Dietary concerns/restrictions:			
Other Health concerns:			
Parent Signature			Date:
M.D. Signature			Date:

Contact Information

Parent/Guardian:		Work	Cell
1)	Phone:		
2)	Phone:		
email:	email:		
Emergency contact: Name: relation:	Phone:		
Primary Care Physician:	Phone:		
Specialty MD:	Phone:		
Director Signature:		Date:	