CAMPBELL COUNTY SCHOOLS
INDIVIDUALIZED HEALTH CARE PLAN AND SELF-ADMINISTRATION AUTHORIZATION

Student Name ______________________ DOB ____________ School ____________
Health Care Provider Name ______________________ Phone ____________ Fax ____________
Date Plan Written or Revised ______________________

Diagnosis:

Treatments/Restrictions Needed During School Day:

Supplies/Special Equipment Needed During School Day:

Possible Emergency Situations and Recommended Responses:

Other Pertinent Information:

Above item should be carried on the bus to and from the school Yes______ No______

PC: Parent
Teacher(s) Guidance
Administration
Bus Driver

Emergency Contact names/phone numbers (optional, copies of this form are shared with those listed on the left of this page):

______________________ ______________________
______________________ ______________________

Self Administration

TO BE COMPLETED BY THE PHYSICIAN: I recommend that the above named student be allowed to carry and self administer the medication listed below:

____
____

List each medication including the dose and frequency; include circumstances warranting us of the medications outside of the indicated frequency.

TO BE COMPLETED BY THE PARENT: I give permission for my child to carry and self administer the medication listed above. My child is both capable and responsible for this and understands the medication is not to be shared. Self administration of medication is a privilege which can be revoked by the principal.

Parent Signature: ______________________ **Date:** ______________________

______________ Date Approved

______________________ Signature of Health Care Provider

______________________ Principal