

THE SCHOOL DISTRICT OF HERNANDO COUNTY, FLORIDA

Generic Medical Care Plan

School _____ Student # _____

Students Name _____ DOB ____ / ____ / ____ Date _____

Parent's/Guardian Name _____ Phone:home _____
work _____
cell _____

Emergency Contact _____ Phone: _____

Physician's Name: _____ Phone: _____

My child's Medical Condition/Concern is _____

My child has had this condition/concern for _____
(length of time)

Are medications required to control the above mentioned medical condition/concern? ___YES ___NO

Name of medication: _____

(If medication is necessary at school please contact the clinic personnel for proper medication forms).

NOTE: No over the counter medication will be administered at school. A Physician must prescribe medication.

IMPORTANT - Please identify situations/events of when you want to be notified: _____

Special needs/limitations:

A. Diet: _____

B. Activity: (Attach Physician's Order:) _____

C. Attached Physician Restrictions: _____

D. Other considerations: _____

Parents Signature: _____ Date: _____

Return this form to the school clinic as soon as possible.

Thank you!