

HEALTH SERVICES

Individual Health Plan

SPRING LAKE PARK SCHOOLS Parent Signature: ______ Date: _____

Provider Signature:______ Date: _____ **GENERAL INFORMATION** _____ Date of birth: _____ Name:_____ Emergency contact: ______ Phone number: _____ Provider: Phone number: **MEDICAL CONDITION** Describe the student's medical history or condition(s): **EMERGENCY PLAN** The proposed treatment protocol/emergency plan is: **ADDITIONAL INSTRUCTIONS**

Additional Instructions continued	

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