Highland Rim Head Start
Individualized Health Action Plan

Date action plan was created: _____

Child's Name: _____ DOB: _____/_____/_____

Parent/Guardian: _____ Phone: _____/_____/_____

Medical Provider: _____ Phone: _____/_____/_____

TO BE COMPLETED BY THE MEDICAL PROVIDER

Diagnosis: _____

Medications

Name of Meds	When to Take Meds	Dosage

If I start having symptoms or signs such as _____you need to (*remain calm)* _____ and

Call my parents/guardian if:
_____
_____
_____
_____
_____

Call my physician if:
_____
_____
_____
_____
_____
_____

Call my 911 if:
_____
_____
_____
_____
_____
_____

Please attach additional records or information as appropriate

Medical Provider Signature: _____ Date: _____

By signing below, you have read, understood, and agree to the plan.

Parent/Guardian: _____ Date: _____

Health Services Manager: _____ Date: _____

Teacher: _____ Date: _____

Revised: 07/01/2022