


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 _____

NAME OF MEDS	MEDICATIONS 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: _____

I have helped develop this health plan. I understand it and will try my best to follow the plan. I will communicate any changes in the child's condition or treatment as relevant to the program.

Parent/Guardian: _____

Date: _____

Health Manager: _____

Date: _____

Teacher: _____

Date: _____