South Boston Catholic Academy

Individual Health Care Plan Form

Name of child: Date of Birth:
Name of chronic health care condition:
Description of chronic health care condition:
Symptoms:
Medical treatment necessary while at the program:
Potential side effects of treatment: Potential consequences if treatment is not administered:
(Optional) Other recommendations (e.g., further tests, treatments, mitigating measures, accommodations required to allow for the child's full participation, etc.)

Name and Phone Number of Licensed Health Care Practitioner (please print):

_____

_____

Parental/Guardian Signature: _____Date:_____

Program Administrator Signature: _____ Date:_____