THE Vanguard School

Confidential Individualized Healthcare Plan

Nurse Zoe Roche 719-471-1999 ext 141

Student Name: **Birth Date** **School** **Grade** **Student #**

Parent/Guardian:	**Name & Phone #**
Parent/Guardian:	**Name & Phone #**
Healthcare Provider	**Primary Care Provider & Phone #**
Healthcare Provider	**Specialist & Phone #**
Preferred Hospital:	**Preferred Hospital**
Emergency Contact:	**Name, Relationship & Phone #**
CURRENT HEALTH ISSUES	
PERTINENT HEALTH HISTORY	
CURRENT MEDICATIONS:	**AT HOME:** **AT SCHOOL:**
ALLERGIES:	
RESTRICTIONS:	relevant activity/diet
CURRENT MEDICATIONS:	**AT HOME**
	AT SCHOOL:
HEALTH PROBLEM(S):	
Problem:	**Goal:** **Action:** ☐
Problem:	**Goal:** **Action:** ☐
Problem:	**Goal:** **Action:** ☐
EMERGENCY ACTION PLAN	Shelter in place Evacuation plan

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and equipment devices. I approve this Individualized Healthcare Plan for my child.

parent/guardian date

school nurse date

health care provider date

administrator date

student (optional) date

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