WINOOSKI SCHOOL DISTRICT
INDIVIDUALIZED HEALTH PLAN

Name:_____ Date of Birth:_____

EMERGENCY PHONE NUMBERS:

1._____

2._____

Condition:_____

Medication:_____

SYMPTOMS SCHOOL PERSONNEL SHOULD BE LOOKING FOR WHICH WOULD INDICATE A PROBLEM:

_____
_____
_____

COURSE OF ACTION SCHOOL PERSONNEL SHOULD FOLLOW:

_____
_____
_____

Signature of Parent/Guardian:_____Date:_____

Signature of Physician:_____Date:_____

Name of Physician (please print):_____Phone:_____

Trained Staff:_____
_____