THE SCHOOL DISTRICT OF HERNANDO COUNTY, FLORIDA

Generic Medical Care Plan

School _____ Student # _____

Students Name _____ DOB _____ / _____ / _____ Date _____

Parent's/Guardian Name _____ Phone:home _____

work _____

cell _____

Emergency Contact _____ Phone:_____

Physician's Name: _____ Phone:_____

My child's Medical Condition/Concern is _____

_____

_____

My child has had this condition/concern for _____

(length of time)

Are medications required to control the above mentioned medical condition/concern? ☐ YES ☐ NO

Name of medication: _____

(If medication is necessary at school please contact the clinic personnel for proper medication forms).

NOTE: No over the counter medication will he administered at school. A Physician must prescribe medication.

IMPORTANT - Please identify situations/events of when you want to be notified: _____

_____

_____

_____

Special needs/limitations:

A. Diet:_____

B. Activity: (Attach Physician's Order:) _____

C. Attached Physician Restrictions: _____

D. Other considerations: _____

Parents Signature:_____Date:_____

Return this form to the school clinic as soon as possible. ***Thank you!***

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Reorder from Printing

DISTRIBUTION
White : School Clinic
Yellow : Parent