Nash-Rocky Mount Public Schools
Student Health Services

Individual Care Plan Information

Student: Date of Birth:	Parent/Guardian:
Today's Date:	Home Phone:
School: Bus:	Work Phone:
Grade: Teacher:	Cell Phone:

Physician:_____ Phone:_____

Medical Condition:_____

Please list/describe symptoms:_____
_____
_____

1. When was your child diagnosed?_____
2. When was the last time your child's doctor was seen for this condition? _____
3. Does your child have any restrictions* relating to activities or diet at school?
   If yes, please list:_____
   _____
   _____
   *A physician's note is necessary for any P.E./activity restrictions or special diet
4. Please list any other concerns or problems related to school. _____
   _____
   _____
   _____

_____ _____
Parent/Guardian Signature Date

Nurse Signature/Date_____
File original in Individual Health Record

Revised: June 2006