Davison Community Schools

HEALTH CARE PLAN

Student's Name _____ Date of Birth _____

Teacher _____ Grade _____

Parent/Guardian _____ Phone Number _____

Work Number _____ Cell Number _____

Emergency Contact _____

(Name) (Relationship) (Phone Number)

Doctor's Name _____ Phone Number _____

Health Condition _____

How does this affect your child at school?

_____

_____

_____

Are there any restrictions? _____Yes _____ No

Please explain

_____

_____

List signs and symptoms of an emergency

_____

_____

Actions to take in an emergency

_____

_____

I understand that this information will be shared with school staff responsible for the care and management of the above health concern for my child.

Reviewed by:

Parent/Guardian _____Date _____

School Representative _____Date _____

Physician _____ Date _____