Lee County School Health Services

Individual Health Care Plan

Please bring or mail this health care plan to the school or send to the secure FAX at 229-903-2130

Student: _____Date of Birth: _____School Year: 20__ - 20___
School: _____ Homeroom Teacher: _____Grade/Team: _____

EMERGENCY CONTACTS

Parent/Guardian/Contact	*Relationship*	*Phone Number*	*Alternate Phone Number*
Healthcare Provider:		*Phone Number:*	

Medical Diagnosis/Condition:

_____
_____

Emergency Care:

_____
_____
_____
_____
_____

Individual Considerations:

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I, this child's parent/guardian, hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Nurse Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's medical condition and for this information to be shared with pertinent school staff at my child's school.. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Lee County Schools. This authorization expires as of the last day of the school year.

_____ _____
Parent Signature Date

_____ _____
Physician Signature Date