



Student Individual Healthcare Plan Information Form

1. Do you have a medical condition or illness that requires routine or emergent care during the school day? Yes No If yes, what is the name of the condition?

2. When and how often is this medical condition a problem for you?

3. How does the condition or illness affect you when the symptoms are most serious?

4. Please list all medications you currently take (over the counter and prescription).

5. Have there been any important changes within the family recently (i.e. moves, births, death, serious illness (family member, friend), separations/divorce): Yes No
If yes, please identify the changes and when they occurred:

6. Describe your behavior and relations with others: peers, siblings, neighbors, and parents (i.e. get along well with others, social, affectionate, withdrawn):

7. Information from a medical provider can be very helpful in determining how to best meet your needs. Please provide any pertinent medical records.

8. Is there any other information about you that you would like the school staff to know?

Name (PRINT)

Signature



UNIVERSITY OF
SOUTH DAKOTA
SANFORD SCHOOL OF MEDICINE

Center for Disabilities