# Highland Rim Head Start
# Individualized Health Action Plan

DATE ACTION PLAN WAS CREATED: ___________

CHILD'S NAME:______________________ _____ DOB: __________

PARENT/GUARDIAN: _______________________ PHONE: _____/_____/______

MEDICAL PROVIDER: _______________________ PHONE: _____/_____/_______

**TO BE COMPLETED BY THE MEDICAL PROVIDER**

DIAGNOSIS__________________________________________________________________________

MEDICATIONS

| NAME OF MEDS | WHEN TO TAKE MEDS | DOSAGE |
|---|---|---|
| | | |
| | | |
| | | |

IF I START HAVING SYMPTOMS OR SIGNS SUCH AS ____________________________________________________

__________________________________________________________________________________________

YOU NEED TO (*remain calm*) ______________________________________________________________AND

Call my parents/guardian if:
________________________
________________________
________________________
________________________
________________________
________________________

Call my physician if:
________________________
________________________
________________________
________________________
________________________
________________________

Call my 911 if:
________________________
________________________
________________________
________________________
________________________
________________________

*Please attach additional records or information as appropriate*

Medical Provider Signature: _____________________________________ Date: __________

By signing below, you have read, understood, and agree to the plan.

Parent/Guardian: _____________________________________ Date: __________

Health Manager: _____________________________________ Date: __________

Teacher: ____________________________________________ Date: __________