# Individualized Health Care Plan

NAME: ___________________________ DOB: _____________ GENDER: ______ ALLERGIES: _____________________________ PRACTITIONER: ___________________

DIAGNOSIS(ES): ____________________________________________________________________________________________________________________________

DIET: ___________________________________ MOBILITY: _________________________ EQUIPMENT: ___________________________________________________

MEDICAL HISTORY: ________________________________________________________________________________________________________________________

MEDICAL TREATMENT: _____________________________________________________________________________________________________________________

SIGNATURE: _____________________________________ SIGNATURE: _________________________________ SIGNATURE: ___________________________________
(PARENT) (STUDENT) (SCHOOL NURSE)

HEALTH CARE GOAL

| DATE | HEALTHPROBLEM/ NURSING DIAGNOSIS | STUDENT OBJECTIVES | INTERVENTION AND RESPONSIBLE PERSON | EVALUATION AND TIMELINE |
|---|---|---|---|---|
| | | | | |

NAME: ____________________________________________

| DATE | HEALTHPROBLEM/ NURSING DIAGNOSIS | STUDENT OBJECTIVES | INTERVENTION AND RESPONSIBLE PERSON | EVALUATION AND TIMELINE |
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NAME: ________________________________________

| DATE | HEALTHPROBLEM/ NURSING DIAGNOSIS | STUDENT OBJECTIVES | INTERVENTION AND RESPONSIBLE PERSON | EVALUATION AND TIMELINE |
|---|---|---|---|---|
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NAME: ________________________________________