Bedford County Public Schools
Health Service Care Plan

This health plan requires parent and physician signature. The plan should be in place prior to the student attending school.

Student Name_____ School_____Grade_____

D.O.B: _____ Doctors Name_____

Doctors Telephone Number: _____ Fax:_____

Description of child's medical condition:

_____
_____
_____
_____
_____

Medical strategies to support the child in school:

_____
_____
_____
_____

Feeding and Nutrition Needs: _☐_none

_____
_____
_____

If special nutritional food or substitutes are needed, notify cafeteria manager and fill out any additional forms.

Procedures or medical orders to be performed at school:

_____
_____
_____
_____

Medications to be given at school: (require additional medication form)

_____
_____
_____
_____

Accessibility Issues: none_____
Bathroom: _____
Cafeteria: _____
Other: _____

Transportation Arrangements: Regular Bus ☐ Special Ed. Bus ☐
Parent Transport ☐ If indicated, notify Transportation Supervisor

Is Staff Training/In service needed: yes ☐ no ☐

If yes, identify staff to be trained, date of training and topics covered:

_____
_____
_____
_____

Emergency Contact Information:

_____
_____
_____

I acknowledge that the information in this plan is accurate and permission is hereby granted for services as described above. I agree to inform the school of any necessary changes to this plan. I give the school nurse permission to contact and exchange information with the physician regarding the medical concerns or care of my child while at school.

_____ _____
Parent/guardian signature **Date**

_____ _____
Physician Signature **Date**