

**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**