

# INDIVIDUAL HEALTH CARE PLAN (IHCP)

## CONFIDENTIAL

Individual Health Care Plan (IHCP) for: \_\_\_\_\_ Medical Condition: \_\_\_\_\_

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1. I would like my child's emergency medication kept in:

the Nurse's Office      the Classroom      the Nurse's office and the Classroom

2. If the emergency medication is kept in the classroom, the medication should be transported by school personnel wherever my child travels to within the school:

Yes      No

3. Does your child require an allergen free eating area?

Yes      No

4. I would like to accompany my child on field trips.

Yes      No

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Accommodations needed at school: *(To be filled out with School Personnel):*

The Individual Health Care Plan has been reviewed and signed by:

Parent Signature

Date