Bellevue Public Schools

Special Health Condition Action Plan

B

NRS 1027-3/23

For: _____
Diagnosis

Student information

Student's name _____ Date of Birth _____

School _____ Grade _____

Please complete this form with current information about your student's special health condition, including actions to take should a problem arise. A new action plan is required each school year to be completed on or after May 1.

Contact information

Parent/Guardian 1 _____

Telephone Home _____ Work _____ Cell _____

Email address _____

Parent/Guardian 2 _____

Telephone Home _____ Work _____ Cell _____

Email address _____

Student's physician/health care provider _____

Address _____

Telephone _____ Fax _____

1. Give us a brief history of your student's condition: _____
   _____
   _____
   _____
   _____

2. What response is required should your student experience difficulties at school? _____
   _____
   _____
   _____
   _____

3. Medication, equipment and/or treatment required at school: _____
   _____
   _____
   _____
   _____

4. Is there any other information you wish to share regarding your student's condition? (i.e., activity restrictions)
   _____
   _____
   _____
   _____

If medication is required at school, please provide the medication with the "Permission for Administration of Medication by School Personnel" form. If a treatment/procedure is required at school, a "Request and Authorization for Specialized Care Procedure" is required.

PLEASE COMPLETE BACK OF PAGE

Special Health Condition Action Plan _____

Student's Last Name Student's First Name

For: _____

Diagnosis

Additional comments: _____

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I understand and agree this information will be reviewed by the school nurse and shared with school staff when appropriate. The school nurse may contact you or your student's physician/health care provider if additional information or clarification is needed. I authorize the school nurse or designated personnel to follow this special health condition action plan and administer medications as detailed in this plan.

Physician Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Reviewed by School Nurse _____ Date _____

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