



## SPECIFIC HEALTH NEED ACTION PLAN

STUDENT \_\_\_\_\_ D.O.B: \_\_\_\_\_

HEALTH NEED \_\_\_\_\_

SHORT TERM NEED

LONG TERM NEED

TIME FRAME FOR SPECIAL INSTRUCTIONS \_\_\_\_\_

SCHOOL \_\_\_\_\_

TEACHER \_\_\_\_\_ GRADE \_\_\_\_\_

MOTHER / LEGAL GUARDIAN \_\_\_\_\_

PHONE \_\_\_\_\_

FATHER / LEGAL GUARDIAN \_\_\_\_\_

PHONE \_\_\_\_\_

Specific Instructions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Parent will provide supplies/equipment.)

Is student released by the physician to return to school?

Yes

No

I, \_\_\_\_\_, authorize the physician's office to release confidential information about my child.

\_\_\_\_\_  
Parent / Legal Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Physician's Phone Number