INDIVIDUALIZED HEALTHCARE PLAN FOR GENERAL OR NONSPECIFIC CONDITION OR DISEASE
2026-2027 SCHOOL YEAR

To be completed by the Parent:

Student Name: _____ Grade: _____

Condition or Disease: _____

EMERGENCY CONTACTS	OTHER EMERGENCY CONTACTS
PARENT/GUARDIAN:_____	NAME:_____
PHONE:_____	PHONE:_____
DOCTOR: _____	NAME:_____
PHONE:_____	PHONE:_____

_____ (Student Name) has _____ as mentioned above and in the Individualized Health Care Plan from the physician. I have provided the school with the physician's medication permission and instructions. I am requesting these instructions be carried out by the school. I have reviewed with my child about his/her condition or disease and told an adult immediately if they have any difficulties. I will provide the medication with a proper pharmacy label and be aware of the expiration date to replace the medication. I hereby request the medication specified by the physician be given to the above-named student, and it may be administered by medical or non-medical personnel. I understand 911 may be contacted if concerns arise.

Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Galveston-Houston, its servants, agents, and any employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston-Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent Signature: _____ Date: _____

To be completed by School:

School Nurse/Health Coordinator Signature: _____ Date: _____

Principal Signature: _____ Date: _____

Before & After Program Coordinator Signature: _____ Date: _____
(If applicable)

Teacher notification provided by: _____ Date: _____

- School staff may be notified of the student's health condition and the treatment plan in case of an emergency.

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To be completed by the Physician:

Students Name: _____ D.O.B.: _____

What is the condition or disease? _____

How can this affect learning? _____

_____

How does this affect the student in school (for example fainting, tiredness, etc.)? _____

_____

Are there any medications or treatments needed at school?

Type of Medication ◯ Prescription ◯ Non-Prescription		Name of Medication and Strength	
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given (Dosage)
For **PRN** state the Frequency (time between dosages of medication and maximum number in a school day			
Reason medication being given			
Form of Medication ◯ Tablet ◯ Capsule ◯ Liquid ◯ Inhalant ◯ Injection ◯ Other _____			Route (ex: oral, nasal)

Type of Medication ◯ Prescription ◯ Non-Prescription		Name of Medication and Strength	
Date to Begin Medication	Date to End Medication	Time to be Given	Amount to be Given (Dosage)
For **PRN** state the Frequency (time between dosages of medication and maximum number in a school day			
Reason medication being given			
Form of Medication ◯ Tablet ◯ Capsule ◯ Liquid ◯ Inhalant ◯ Injection ◯ Other _____			Route (ex: oral, nasal)

What care is necessary for the student while the student is in school or attending school-related activities? _____

_____

Any school restrictions? _____

What problems or emergencies can arise? _____

_____

What is to be done by the school? _____

_____

What is the student's responsibility? _____

_____

Any other information the school should know about the care of the student? (Please attach any documents if necessary) _____

_____

Physician signature: _____ **Phone:** _____ **Date:** _____