Lake Country School District
1800 Vettelson Road, Hartland, WI 53029
Phone: 262-367-3606 | FAX: 262-367-3205
www.mylakecountryschool.org

LAKE COUNTRY SCHOOL

General Health Care Plan

Student's Name: _____
Last *First* *Middle Initial*

Student's Date of Birth: _____ **Student's Grade:** _____

Current Street Address: **Phone Number:** _____

_____
Street *City* *Zip*

Medical Concern (illness/injury/condition):

_____

_____

_____

_____

Present Symptoms and Status:

_____

_____

_____

Medication #1: _____ **Dose:** _____

Time(s) Given: _____ **Side Effects:** _____

Medication #2: _____ **Dose:** _____

Time(s) Given: _____ **Side Effects:** _____

Medication #3: _____ **Dose:** _____

Time(s) Given: _____ **Side Effects:** _____

What concerns/actions should be taken to care for your child?

❑ In Class: _____

_____

❑ In Physical Education: _____

_____

❑ During Field Trips: _____

_____

❑ After School Activities (please advise coach/leader): _____

_____

❑ Other (lunch, recess, foods, band, tech ed, school bus, etc.): _____

_____

Any signs/symptoms that require emergency care:

If you see this:	Action for staff to take:

Your hospital preference (will be honored if possible): _____

❑ Yes, I give the school nursing staff permission to share medical information with my child's physician/clinic.
❑ No, I do not give the school nursing staff permission to share medical information with my child's physician/clinic.

This information may be shared in confidence with pertinent staff. This information will be shared with medical personnel during an emergency situation. Your signature certifies that you give permission to Lake Country School staff to provide care, as you have indicated on this General Health Care Plan, and to share information as indicated above.

_____ _____
Signature (Parent/Guardian) *Date*

_____ _____
Signature (Parent/Guardian) *Date*

_____ _____
Signature (Physician) *Date*

_____ _____
Print Physician's Name *Physician's Phone Number*