The Brook Hill School
Christ-Centered. College Prep.

Individual Health Plan for: _____

Student's Name: _____ Birthdate: _____

Guardian #1: _____Phone: _____

Guardian #2: _____Phone: _____

Other Emergency Contact: _____Phone: _____

Physician: _____Phone: _____

Daily Medications:

_____

_____

_____

_____

Chronic Illness/ Condition or Special Need:

_____

_____

_____

_____

Instructions for Care:

_____

_____

_____

_____

_____

School staff interacting directly with my child may be informed about his/her special needs while at school.

Doctor's Signature_____ **Date**_____

Parent/Guardian Signature_____ **Date:** _____

Nurse Signature: _____**Date:** _____