GRIFFIN-SPALDING COUNTY SCHOOLS
STUDENT SPECIFIC HEALTH CARE PLAN
SCHOOL YEAR: ___________

Student's Name: ________________________ D.O.B.: ___________ Teacher: ________________
School: ____________________________________ Grade/Team: ____________________
Parent/Guardian's Name: ________________ Home Phone: ____________ Other: ____________
Mother's Work #: ____________________________ Father's Work #: ____________________

Emergency Contact Name: ____________________ Relationship: ______________________
Home Phone: ______________________________ Other: ______________________________

Health Information to Nurse/Teacher:
This student has a health condition you need to be aware of. A description of this condition, as well as emergency care and individual considerations, are stated below:

Medical Diagnosis/Condition:

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Emergency Care:

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Individual Considerations (including procedures):

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Physician's Signature: ______________________________ **Date:** ______________
Physician's Name: ______________________________ **Phone Number:** ______________

I, (parent/guardian) ________________________, hereby authorize (Healthcare Provider) ____________, who has attended to my child, ________________________, to furnish to the (School Nurse Supervisor or designee), any medical information and/or copies of records pertaining to my child's chronic health condition and for this information to be shared with pertinent school staff. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act (HIPPA), disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Griffin-Spalding County Schools. This authorization expires as of the last day of the school year.

Parent/Guardian's Signature: ______________________________ **Date:** ______________

School Nurse/Administrator: ______________________________ **Date:** ______________