

St. Matthew School
Health Care Plan
Mental Health

Student's Name _____ Grade/teacher _____

Diagnosis/Student condition _____

Date of birth _____

Current medications _____

Allergies _____

Action Plan

Actions to be taken at school:

School nurse will provide the following information to school staff:

Any additional health concerns:

Medication delivered to school _____

Parent Contact

MD contact name and number _____

MD signature: _____

I give permission for my child to be given the above care

Parent signature _____

Date _____

School nurse signature _____

Date _____