Individual Health Care Plan

Student Name

Medical Condition

Medication Name

Self administered? **Yes** **No**

Dosage

Date medication dispensed
(DD/MM/YY)

Medication Expiry Date
(DD/MM/YY)

Student's Condition and Individual Symptoms

Daily Care Requirements

Procedures to Take in an Emergency (if applicable)

Additional Information (if needed)

Details of Person Completing this Form:

Name

Email Address

Signed

Date
(DD/MM/YY)