Westford Public Schools
Individual Health Care Plan
Student with Ambulatory Restrictions or Crutches

Attach student picture here

Student's Name: _____ **School Year:**_____

DOB:_____ **Teacher:**_____ **Grade:**_____

Pertinent Medical History:

Level of Ability

- o Maneuvers level ground
- o Maneuvers uneven ground
- o Maneuvers stairs competently ____alone ____with adult supervision
- o Must use elevator Supervision plan: ____ with another student ____ adult

Classroom Modification

- o Extra set of books (secondary students and teachers)
- o Permission to leave classrooms early to avoid crowds on stairs and in halls
- o Permission to be accompanied by classmate
- o Permission to rest, ice, and elevate affected limb in the health office or classroom if needed
- o Pain medication plan: _____
- o Sports/Phys Ed restrictions: _____

Transportation:

To School: _____ From School: _____

Emergency Contacts:

Parent/Guardian Name(s)	**Home Phone**	**Cell Phone**	**Work Phone**
_____	_____	_____	_____
_____	_____	_____	_____

Other Emergency Contact if parent/guardian is unavailable:

Name: _____ Relationship: _____ Tel. # _____

Primary Care Provider: _____ **Tel. #** _____

Specialist: _____ **Tel. #** _____

I consent to have the school nurse or school personnel designated by the school nurse carry out the above plans. I give permission for the school nurse to share information and to complete staff training in order to carry out the above plans as determined appropriately for my student's health and safety.

Parent/Guardian Signature: _____ Date:_____

Physician Signature: _____ Date: _____

Nurse Signature: _____ Date: _____