

**Newburyport 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:

Potential Problems:

Level of Ability

- Maneuvers level ground
- Maneuvers uneven ground
- Maneuvers stairs competently _____ alone _____ with adult supervision
- Must use elevator Supervision plan : _____ with another student _____ adult

Classroom Modification

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

Transportation:

To School: _____ From School: _____

If bus is to be used, indicate responsible adult to monitor/assist student on and off :

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: _____ **Telephone#** _____

Specialist: _____ **Telephone#** _____

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 she determines appropriate for my child's health and safety.

Parent Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Nurse Signature: _____ Date: _____