

San Diego Unified School District  
Nursing & Wellness Program

**Individualized School  
Healthcare Plan (ISHP)**

**Physician Information:**  
**Physician's Name:**  
  
**Physician's Phone:**

**Emergency Contacts:**  
*(List by priority of contact.)*

<u>Name</u>	<u>Phone</u>
1. <input type="text"/>	<input type="text"/>
2. <input type="text"/>	<input type="text"/>
3. <input type="text"/>	<input type="text"/>

**Student Name:**  **DOB/ID #:**  **Date:**

**School Site:**  **Rm. #**  **School Phone:**

**MEDICAL DIAGNOSIS/PROBLEM AND DESCRIPTION:**

**SYMPTOMS TO WATCH FOR:**

**HEALTH CARE ACTION PLAN:**

**DESIGNATED STAFF:**

Name	Completed Training Date	Name	Completed Training Date
<input type="text"/>	/ /	<input type="text"/>	/ /
<input type="text"/>	/ /	<input type="text"/>	/ /
<input type="text"/>	/ /	<input type="text"/>	/ /

**DISTRIBUTION DATE(S):**

- |                                    |            |  |            |
|------------------------------------|------------|--|------------|
| <input type="checkbox"/> Principal | Date _____ | <input type="checkbox"/> Parent/Guardian | Date _____ |
| <input type="checkbox"/> Teacher * | Date _____ | <input type="checkbox"/> Other _____     | Date _____ |

(\* Include copy in your substitute folder)

**School Nurse Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_