



ST. MARY'S SPRINGS ACADEMY
INDIVIDUAL HEALTH PLAN 2025-2026

Student: _____ **Date of Birth:** _____

Grade: _____ **Diagnosis:** _____

Parent/Guardian Information:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Parent Consent For Management of Health Condition While At School

I, the parent/guardian of the above named student, request that this plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Agree to school staff interacting directly with my child being informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature: _____ **Date:** _____

Provider Information & Consent

Name of Provider (Print): _____ Clinic Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

Signature of Provider: _____ **Date:** _____

Recommended Response Protocol and Additional Information:

All medications must not be expired and contained in a properly-labeled pharmacy box/bottle. Parents/Guardians may ask their pharmacy for any additional labels or containers, as needed. Medication will not be accessible to students during after school hours for athletics or other extracurricular activities. All medications administered by SMSA staff are only available during school hours, with the exception of students enrolled in the Before/After School Care Program.