Student Medical Treatment Plan for Chronic Illnesses

To be completed by Physician/NP/PA

Student Name: _____ DOB_____ YOG_____School Year_____

Student's Primary Diagnosis or Presenting Problem(s): Describe characteristics and symptoms of disorder(s).

1)

2)

3)

Onset of Disorder/Illness & Last Episode: _____

_____

Current Medications:

Medication	Dose	Frequency	Duration	Indication

Treatment Plan

Please list below step by step plan of treatment for each health problem. Describe symptoms or behaviors.

Health Problem/Disorder/Symptoms	Treatment Plan

Additional Comments: _____

_____

_____ _____

Student Signature Date

_____ _____

Parent / Guardian Signature Date

_____ _____

Physician (MD, NP, PA) Signature Date

REQUIRED: Apply Physician's Address Stamp Below:

_____ _____

TCHS School Nurse Signature Date