Alachua County Public Schools
Head Start Program

Individualized Care Plan

(Check One)

☐ **Health** ☐ **Nutrition** ☐ **Combination**

School:_____ School Year:_____

Name:_____ DOB:_____ Age:_____ ☐ Male ☐ Female

Parent/Guardian:_____ Phone #:_____

Health Care Provider:_____ Phone #:_____

Medical Diagnosis:

Allergies/Reactions/Precautions:

Special Health Needs/Treatments/Medications:

Plan of Treatment/Protocol

Notified:

Teacher:_____ Date:_____

Parent:_____ Date:_____

Head Start Nurse/Designee:_____ Date:_____