South Bend Community School Corporation
Special Education Services

Health Plan

Student Name: _____ SBCSC ID#: _____ STN#: _____

School: _____ Grade: _____ Age: _____

School Nurse: _____ Emergency Phone #: _____

Doctor: _____ Hospital Preference: _____

Diagnosis (es):	Medication needs/Dosages:
Allergies:	Medical Equipment:
Nutrition and Feeding:	Skin Care Dressings:
Tubes:	Bowel/Bladder Care:
O2 Needs:	Orthopedic Equipment Usage:
Respiratory Treatments:	
Suction:	OT/PT/SLP Service:
Ventilator	

Comments: