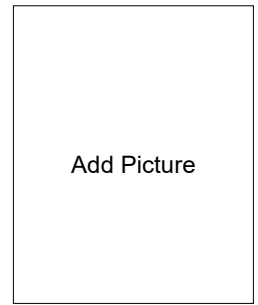


INDIVIDUALIZED HEALTH CARE PLAN

Livonia Public Schools

Confidential

Name:	School Year:
Health Concern:	
Date of Birth:	Student ID:
Case Manager:	Ext:



The following individuals have reviewed this Health Care Plan and support its implementation.

Parent / Guardian Signature Date _____
Administrator Signature Date _____
Doctor Signature (required) Date