DIGESTIVE DISORDER HEALTH CARE PLAN/504

Student picture here

Date plan created:	Date plan revised:	Nurse:	Nurse phone:
Name		Birthdate	Teacher
Grade	School	Allergy notification card made? ☐	Signature:

Examples of Digestive Disorders: Crohn's, GERD, Irritable Bowel Syndrome, Ulcerative Colitis, Celiac Disease, Inflammatory Bowel Disease

Describe how the impairment affects the child (*to be completed by LHP*):

History (*to be completed by LHP*):

☐ ***Check if school food substitution is needed.***
Explain what must be done to accommodate the child's diet (*to be completed by LHP*):

List food(s) and/or beverages to be substituted, provided, or modified (*Parent can help plan menu choices by reviewing menus made available on line by Nutrition Services, or by calling 354-7270)*:

**The regular menu item will be provided if it meets the dietary requirements.*
**Standard substitution will be provided from items available in the District warehouse.*

LHP Signature	Date	Telephone: Fax Number:
LHP Printed Name	Start Date:	End Date:

PARENT/GUARDIAN SECTION

EMERGENCY CONTACTS

Name
Home Phone
Work Phone
Other

Name
Home Phone
Work Phone
Other

ADDITIONAL EMERGENCY CONTACTS:

1.	Relationship:	Phone:
2.	Relationship:	Phone:

****Does the student need classroom, lunch room, school activity, or recess accommodations? ___yes ___no. If yes, please contact the school counselor.**

**** I do not give Nutrition Services staff permission to provide the student with a beige lunch tray and allergy identification card to use when eating school breakfast and lunch. ☐ (elementary only)**

- A new health care plan for Digestive Disorders must be submitted each school year.
- I understand that if any changes are needed on the Digestive Disorder Health Care Plan, it is the parent's responsibility to contact the school nurse.
- It is the parent's responsibility to alert all other non-school programs of their child's health condition.
- Medical information may be shared with school staff working with your child and 911 staff, if they are called.
- I have reviewed the information on this Health Care Plan and request/authorize trained school employees to provide this care in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- I understand this is a Health Care Plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child's Digestive Disorder between the LHP office and the school nurse.
- *My signature below shows I have reviewed and agree with this Health Care Plan.*

Parent/Guardian Signature Date

Nurse Signature Date