GOVERNMENT OF DUBAI

DUBAI HEALTH AUTHORITY

Public Health Protection Department- School Health Section

Individualized Health Care Management in School (IHP)

Student Full Name: _____ **D.O.B.**_____ **Sex:** ☐ **Male** ☐ **Female**

Name of school: _____ **Grade:**_____ **Academic Year** (/)

Student ID:_____

Hasana ID:_____

Emirates ID:_____

Medical Condition: _____

Special precautions: _____

Allergies: _____

Treating physician Details:

Name: _____

Workplace: _____

Contact No:_____

School Medical staff Details:

Name:_____

License ID No & Signature:_____

Date of Assessment: _____

I acknowledge that I have read, understand this plan, and agree on its implementation. I understand that this plan is valid for one academic year, unless there is any changes in my child's health status.

I will notify the school immediately if there is any changes in my child's health status.

Parent/ Guardian name:_____**Signature:**_____**Phone:** _____**Date:**_____

Assessment data	Nursing diagnosis	Goals	Nursing interventions	Expected outcomes

ID	Issue#	Issue Date	Effective Date	Revision Date	Page#
CP_6.2.14_F03	01	Jul 01, 2020	Sep 01, 2020	Jul 01, 2023	1/1

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CP_6.2.14_F03	01	Jul 01, 2020	Sep 01, 2020	Jul 01, 2023	2/1