PLAN OF CARE — GENERAL

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s) _____

Student Photo (optional)

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

PHYSICAL CONDITION(S)

CHECK (✓) THE APPROPRIATE BOXES

❒ Vision Loss	❒ Hearing Loss	❒ Hearing Loss
❒ Spinal Cord Injury	❒ Anosmia	❒ Irritable Bowel Syndrome
❒ Spina Bifida	❒ Somatosensory loss	❒ Heart condition
❒ Cerebral palsy	❒ Ageusia	❒ Cancer
❒ Cystic fibrosis	❒ Brain injury	❒ Glaucoma
❒ Multiple sclerosis	❒ Organ damage	❒ Other: _____
❒ Muscular dystrophy	❒ Arthritis	_____
❒ Tourette syndrome	❒ Eczema	_____

ASSISTIVE EQUIPMENT

CHECK (✓) THE APPROPRIATE BOXES

❒ Wheelchair	❒ Artificial Limb(s)	❒ Back brace
❒ Rifton Chair	❒ Prescription Glasses	❒ Hearing aid
❒ Gastro-Feeding	❒ Specialized Software	❒ Crutches/walker

❒ Other: _____

_____

MEDICATION

COMPLETE BELOW IF STUDENT REQUIRES MEDICATION

ROUTINE	ACTION
❒ Medication is given by: ❒ Student ❒ Student with supervision ❒ Parent(s)/Guardian(s) ❒ Trained Individual ❒ Student takes medication at school by: ❒ Ingestion ❒ Skin contact ❒ Injection ❒ Inhalation ❒ Other: _____	Name of medication: _____ Dosage: _____ Location of medication: _____ _____ Required times for medication: _____ ❒ Before school ❒ Morning Break ❒ Lunch Break ❒ Afternoon Break ❒ Other (Specify): _____ Parent(s)/Guardian(s) responsibilities: _____ School Responsibilities: _____ Student Responsibilities: _____ Additional Comments: _____

ADDITIONAL ASSISTANCE

DEGREE OF ASSISTANCE

❒ Student requires additional assistance on a daily/routine basis.

❒ Student requires additional assistance for specific circumstances.

❒ Student does not require additional assistance.

❒ Other (explain): _____

PLAN OF ACTION

Specify student's limitations.	
Specify additional assistance to be provided by trained staff.	

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
✸This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1. _____ 2. _____ 3._____

4._____ 5._____ 6._____

Other individuals to be contacted regarding Plan Of Care:

Before-School Program ❒Yes ❒ No _____

After-School Program ❒ Yes ❒ No _____

School Bus Driver/Route # (If Applicable) _____

Other: _____

This plan remains in effect for the 20___— 20___ school year without change and will be reviewed on or before: _____. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year.)

Parent(s)/Guardian(s): _____ Date: _____
Signature

Student: _____ Date:_____
Signature

Principal: _____ Date: _____
Signature