PREVALENT MEDICAL CONDITION — OTHER
Plan of Care

STUDENT INFORMATION

Student Name _____	Date Of Birth _____	Student Photo (optional)
Ontario Ed. # _____	Age _____	
Grade _____	Teacher(s)_____	

MEDICAL CONDITION

Please Specify:_____

EMERGENCY CONTACTS (LIST IN PRIORITY)

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

EMERGENCY PROCEDURES

IF ANY OF THE FOLLOWING OCCURS:

_____
_____
_____
_____

TAKE THE FOLLOWING ACTION: (Please list in order of importance)

_____
_____
_____
_____
_____

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

In order to ensure your child's safety at all times, it is important that this Plan of Care be shared with the following, if applicable:

- All School Staff
- Transportation Dept. (including the bus driver)
- Volunteers in direct contact with my child, ie. coaches, food program volunteers, etc.
- Food Services Workers, ie. cafeteria staff
- Other_____

Other individuals to be contacted regarding Plan Of Care:

Before-School Program ❒Yes ❒ No _____

After-School Program ❒ Yes ❒ No _____

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