



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

- | | | |
|---|---|---|
| <input type="checkbox"/> Vision Loss | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Spinal Cord Injury | <input type="checkbox"/> Anosmia | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Somatosensory loss | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Ageusia | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Brain injury | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Organ damage | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Arthritis | _____ |
| <input type="checkbox"/> Tourette syndrome | <input type="checkbox"/> Eczema | _____ |

ASSISTIVE EQUIPMENT

CHECK (✓) THE APPROPRIATE BOXES

- | | | |
|---|---|--|
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Artificial Limb(s) | <input type="checkbox"/> Back brace |
| <input type="checkbox"/> Rifton Chair | <input type="checkbox"/> Prescription Glasses | <input type="checkbox"/> Hearing aid |
| <input type="checkbox"/> Gastro-Feeding | <input type="checkbox"/> Specialized Software | <input type="checkbox"/> Crutches/walker |

Other: _____

MEDICATION

COMPLETE BELOW IF STUDENT REQUIRES MEDICATION

ROUTINE	ACTION				
<p><input type="checkbox"/> Medication is given by:</p> <ul style="list-style-type: none"><input type="checkbox"/> Student<input type="checkbox"/> Student with supervision<input type="checkbox"/> Parent(s)/Guardian(s)<input type="checkbox"/> Trained Individual <p><input type="checkbox"/> Student takes medication at school by:</p> <ul style="list-style-type: none"><input type="checkbox"/> Ingestion<input type="checkbox"/> Skin contact<input type="checkbox"/> Injection<input type="checkbox"/> Inhalation<input type="checkbox"/> Other: _____	<p>Name of medication: _____</p> <p>Dosage: _____</p> <p>Location of medication: _____</p> <p>_____</p> <p>Required times for medication: _____</p> <table border="0"><tr><td><input type="checkbox"/> Before school</td><td><input type="checkbox"/> Morning Break</td></tr><tr><td><input type="checkbox"/> Lunch Break</td><td><input type="checkbox"/> Afternoon Break</td></tr></table> <p><input type="checkbox"/> Other (Specify): _____</p> <p>Parent(s)/Guardian(s) responsibilities: _____</p> <p>School Responsibilities: _____</p> <p>Student Responsibilities: _____</p> <p>Additional Comments: _____</p>	<input type="checkbox"/> Before school	<input type="checkbox"/> Morning Break	<input type="checkbox"/> Lunch Break	<input type="checkbox"/> Afternoon Break
<input type="checkbox"/> Before school	<input type="checkbox"/> Morning Break				
<input type="checkbox"/> Lunch Break	<input type="checkbox"/> Afternoon Break				

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