APPENDIX E: PLAN OF CARE — GENERAL

STUDENT INFORMATION			
School	Age	Homeroom Teacher	Student Name

PLAN OF CARE — GENERAL

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

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

PHYSICAL CONDITION(S)

CHECK (✓) THE APPROPRIATE BOXES

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

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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:

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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.	

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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 (POC) IS TO BE SHARED:
Note: Only individuals involved in the daily/routine management require the entire Plan of Care. All others will receive Emergency Procedures Section only.

Please select one of the following:

☐ DSBN Teaching and Support Staff, Niagara Student Transportation Services and food service providers.

☐ Only those listed below: ________________________

____

____

Parent(s)/Guardian(s): ______________________________ Date: ______________________
Signature

Student: ______________________________ Date: ______________________
Signature

Principal: ______________________________ Date: ______________________
Signature

Personal information and personal health information on this form is collected, used and disclosed in accordance with the Education Act, R.S.O. 1990, c.E.2, as amended, the Municipal Freedom of Information and Protection of Privacy Act. R.S.O 1990, c.M. 56, as amended and the Personal Health Information Protection Act, 2004, c.3 Sched. A., as amended and will be used for the purpose of providing student health information for the Plan of Care and any similar or related purpose(s). Questions about this collection, use and disclosure should be directed to the Freedom of Information Coordinator, District School Board of Niagara, 191 Carlton Street, St. Catharines, ON L2R 7P4 905-641-1550