APPENDIX E: PLAN OF CARE — GENERAL

STUDENT INFORMATION

School	Age	Homeroom Teacher	Student Name

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s) _____

Other medical condition/allergy? MedicAlert® ID ☐ Yes ☐ No

_____

EMERGENCY CONTACTS (LIST IN PRIORITY)

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

HEALTH CONDITION(S)

CHECK (✓) THE APPROPRIATE BOXES

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

APPENDIX E: PLAN OF CARE — GENERAL

STUDENT INFORMATION

School _____ Age _____ Homeroom Teacher _____ Student Name _____

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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STUDENT INFORMATION

School	Age	Homeroom Teacher	Student Name
_____	_____	_____	_____

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.	

APPENDIX E: PLAN OF CARE — GENERAL

STUDENT INFORMATION

School _____ Age _____ Homeroom Teacher _____ Student Name _____

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
Please select one of the following:

- ☐ DSBN Teaching and Support Staff, Niagara Student Transportation Services and food service providers.
- ☐ Only those listed below:

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

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