# PLAN OF CARE

## PREVALENT MEDICAL CONDITION: _____

*(Identify Prevalent Medical Condition)*

### STUDENT INFORMATION

| | | |
|---|---|---|
| School: | Date: | |
| Student Name: | Date of Birth: | |
| Ontario Education #: | Age: | |
| Grade: | Teacher(s): | |
| Diagnosis: | | |
| Medication(s): | | |

### EMERGENCY CONTACTS *(Please list in order of priority)*

| # | Name | Relationship | Daytime Phone | Alternate Phone |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Has emergency medication been prescribed? ☐ Yes ☐ No

If yes, attach the Medication Plan, healthcare providers' orders and authorization from the student's parent(s)/guardian(s) for a trained person to administer the medication.

Note: Medication delivery training for the prescribed medication, and route of administration, must be done in collaboration with a regulated healthcare professional.

### DESCRIPTION OF MEDICAL CONDITION

## DAILY MANAGEMENT / ACTIONS

Describe what measures need to be taken to support daily management of the condition.

## PREVALENT MEDICAL CONDITION INFORMATION

| Symptoms | Description | Actions/Treatment |
|---|---|---|
| | | |

## BASIC FIRST AID: COMFORT AND CARE

First aid / care procedure(s):

## EMERGENCY RESPONSE

Call 9-1-1 when:

* Notify parent(s)/guardian(s) or emergency contact.

## HEALTHCARE PROVIDER INFO.

***Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, etc.***

| | |
|---|---|
| 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 | Contact Info.: |
| After-School Program | ☐ Yes | ☐ No | Contact Info.: |

School Bus Driver / Route # (If Applicable)

Other:

| | | |
|---|---|---|
| Permission is granted to store this Plan of Care on the S:/drive? ☐ Yes ☐ No | | |
| This Plan of Care 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): | Signature: | Date: |
| Parent(s) / Guardian(s): | Signature: | Date: |
| Student: | Signature: | Date: |
| Principal: | Signature: | Date: |