LIFE-THREATENING MEDICAL CONDITION – Plan of Care 518-5

Student Name: _____ Date of Birth: _____

Student Photo

Grade: _____ Teacher: _____

EMERGENCY CONTACTS (LIST IN PRIORITY)

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

MEDICAL CONDITION

Specific medical condition requiring a plan of care:

_____

_____

Symptoms of medical distress: _____

_____

_____

_____

Response to medical distress: _____

❒ DNR

_____

_____

_____

Student specific monitoring: _____

_____

_____

_____

Support strategies: _____

_____

_____

_____

HEALTH CARE PROVIDER INFORMATION

I hereby agree with the diagnosis of this student, the medication, and this plan of care.

_____ _____ _____

Health Care Provider (Please print) Signature Date

Additional Information:

_____

_____

_____

_____

AUTHORIZATION /PLAN REVIEW

This Plan remains in effect for the 20___ - 20___ school year. (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)/Student (if age 18+)

_____ _____

Signature Date

_____ *(Parent Initial) I authorize the sharing of this plan with principals, teachers, support staff, volunteers, bus operators and drivers, and other adults as appropriate, which may include the posting in designated locations.*

_____ *(Parent Initial) I authorize the sharing of signs and symptoms of this medical condition with other students.*

Authorization for the collection of this information is in the Education Act. The purpose is to collect and share medical information and to administer proper medical care in the event of an emergency or life-threatening situation. The original form and all copies will be retained and securely destroyed in accordance with the board's Records Management Manual and Policy 316. Contact person concerning this collection is the school principal.