PREVALENT MEDICAL CONDITION — OTHER
Plan of Care

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Student Photo (optional)

			[redacted]
1.			
2.			

EMERGENCY PROCEDURES

IF ANY OF THE FOLLOWING OCCURS:

_____
_____
_____
_____

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
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AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

In order to ensure your child's safety at all times, it is important that this Plan of Care be shared with the following, if applicable:

- ¾ All School Staff
- ¾ Transportation Dept. (including the bus driver)
- ¾ Volunteers in direct contact with my child, ie. coaches, food program volunteers, etc.
- ¾ Food Services Workers, ie. cafeteria staff
- ¾ Other_____

Other individuals to be contacted regarding Plan Of Care: