## PLAN OF CARE — GENERAL

### STUDENT INFORMATION

School _____ Age _____ Homeroom Teacher _____ Student Name _____

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### STUDENT INFORMATION

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s) _____

Student Photo (optional)

### EMERGENCY CONTACTS (LIST IN PRIORITY)

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

### PHYSICAL 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
_____

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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:<br>❒ Student<br>❒ Student with supervision<br>❒ Parent(s)/Guardian(s)<br>❒ Trained Individual<br><br>❒ Student takes medication at school by:<br>❒ Ingestion<br>❒ Skin contact<br>❒ Injection<br>❒ Inhalation<br>❒ Other: _____ | Name of medication: _____<br>Dosage: _____<br>Location of medication: _____<br>_____<br>Required times for medication: _____<br>❒ Before school ❒ Morning Break<br>❒ Lunch Break ❒ Afternoon Break<br>❒ Other (Specify): _____<br>Parent(s)/Guardian(s) responsibilities: _____<br>School Responsibilities: _____<br>Student Responsibilities: _____<br>Additional Comments: _____ |

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| 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. | |

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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 provide the prescription 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