KAWARTHA PINE RIDGE DISTRICT SCHOOL BOARD

PREVALENT MEDICAL CONDITION — General Health Concerns:
Plan of Care

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____ Student Photo (optional)

Grade _____ Teacher(s) _____

EMERGENCY CONTACTS (LIST IN PRIORITY)

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

Medical Concern(s) (list most serious first): _____
(Anaphylaxis, Type 1 Diabetes, Epilepsy, Asthma have individual Plan of Care Forms)

Additional information: _____

Wears Medic Alert: ☐ Yes ☐ No

KNOWN TRIGGERS

CHECK (✓) ALL THOSE THAT APPLY

☐ Stress ☐ Menstrual Cycle ☐ Inactivity

☐ Changes In Diet ☐ Lack Of Sleep ☐ Electronic Stimulation (TV, Videos, Florescent Lights)

☐ Illness ☐ Improper Medication Balance

☐ Change In Weather ☐ Other _____

☐ Any Other Medical Condition or Allergy? _____

DAILY/ROUTINE MANAGEMENT

SYMPTON DESCRIPTION:	ACTION: (precautionary and emergency response actions)
	(example: description of dietary therapy, risks to be mitigated, trigger avoidance)
MEDICATION(S):	**LOCATION/TREATMENT:**

BASIC FIRST AID: CARE AND COMFORT

First aid procedure(s): _____

_____

EMERGENCY PROCEDURES

Students who require emergency medical assistance as a result of their medical condition:

Call 9-1-1 when:

- _____
- _____

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

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, or Pharmacist.

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 _____

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