HEALTH CARE PLAN (Other) _____

This form should be completed for serious health conditions that require emergency procedures and daily routine management.

Diagnosis of the Condition

_____

_____

_____

STUDENT INFORMATION

Student Name_____ Date of Birth _____

Age _____

Grade_____Teacher(s) _____

Student Photo

EMERGENCY PROCEDURES

IF ANY OF THE FOLLOWING OCCUR:

-
-
-
-

TAKE ACTION:

STEP 1:

STEP 2:

IF ANY OF THE FOLLOWING OCCUR:

-
-
-
-

THIS IS AN EMERGENCY:

STEP 1:
Call 9-1-1 for an ambulance. Follow 9-1-1 communication protocol with emergency responders.
STEP 2:
While waiting for medical help to arrive:

- ✓ Stay Calm, reassure the student and stay by his/her side.

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

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

DAILY/ ROUTINE MANAGEMENT

Storage and location of spare medication and other supplies if applicable:

_____

_____

Disposal of unused medication and medical supplies if applicable (supply and disposal of unused medication and/or medical supplies are facilitated by the family):

_____

_____

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:_____unless otherwise notified by parents of need to revisit the Plan. (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.)

I/We hereby request that the York Region District School Board, its employees or agents, as outlined, administer the above procedure to my/our child. The York Region District School Board employees are expected to support the student's daily or routine management, and respond to medical incidents and medical emergencies that occur during school, as outlined in board policies and procedures. Parent(s)/guardians and students

Parent(s)/Guardian(s): _____ Date: _____
Signature

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature

Authorization for the collection of this information is in accordance with the *Education Act*, the *Municipal Freedom of Information and Protection of Privacy Act*, and the *Personal Health Information Protection Act,* as amended and applicable. 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.
Users of this information include but are not limited to principals, teachers, support staff, volunteers, and bus drivers. This form will be kept for a minimum period of one calendar year. Contact person concerning this collection is the school principal.

Distribution: Original: Secure location accessible by school staff

Original: Scanned and uploaded to SSNET

Original: Scanned and copy sent to Student Transportation

Copy: Parent/Guardian

Copy: File in the OSR

RETAIN: Current school year + 1 year

Relevant Forms:

P662.02 Staff Administration of Medication

P662.03 Self-Administration of Medication

Medical Incident Record Form