ESSENTIAL ROUTINE HEALTH CARE PLAN

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

Diagnosis of the Condition:

_____

_____

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

Age_____

Student Photo (optional)

Grade _____ Teacher(s) _____

DAILY/ ROUTINE MANAGEMENT

Part I: DESCRIPTION OF HEALTH/MEDICAL CONDITION (S):

Part II: <u>ROUTINE CARE PLAN</u>:
(Complete Part II separately for each service required. NOTE: Provision of medication to manage an ongoing medical condition is considered an essential routine service.)

Describe the care required:

How often is care required?

Describe the student's ability to self-administer care:

Additional instructions (i.e. apparatus, equipment, storage, care of equipment, accessibility of medication)

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):

Parent's Responsibilities:

School's Responsibilities:

Student's Responsibilities:

Please provide any other information that would help us understand your child's needs:

STAFF INVOLVED IN PROVISION OF THE ESSENTIAL ROUTINE HEALTH SERVICES:
Name /Title

HEALTH CARE PROFESSIONAL REVIEW

The Essential Routine Health Services Plan of this student has been reviewed. This review has occurred in conjunction with YRDSB PT/OT Services ☐ YES ☐ NO ☐ OTHER

_____

Name of Regulated Health Provider

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 acknowledge that the employees of the York Region District School Board, who will administer the related procedures, are not medically trained. At all times it remains the responsibility of the parent(s)/guardians to ensure that clear instructions and current physician's orders are provided to the principal.

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.

Note: if the requirements of the service requested have changed, complete a new Essential Routine Services form. If there are no changes, use this sign-off sheet to confirm the plan has been reviewed with the parent.

THIS PLAN REMAINS IN EFFECT FOR THE____-____SCHOOL YEAR WITHOUT CHANGE.

Parent(s)/Guardian(s): ______________________________ Date: ______________________
Signature

Student: ____ Date:_______________________
Signature

Principal: _______________________________________ Date: ______________________
Signature

THIS PLAN REMAINS IN EFFECT FOR THE____-____SCHOOL YEAR WITHOUT CHANGE.

Parent(s)/Guardian(s): ______________________________ Date: ______________________
Signature

Student: ____ Date:_______________________
Signature

Principal: _______________________________________ Date: ______________________
Signature

THIS PLAN REMAINS IN EFFECT FOR THE____-____SCHOOL YEAR WITHOUT CHANGE.

Parent(s)/Guardian(s): ______________________________ Date: ______________________
Signature

Student: ____ Date:_______________________
Signature

Principal: _______________________________________ Date: ______________________
Signature

THIS PLAN REMAINS IN EFFECT FOR THE____-___SCHOOL YEAR WITHOUT CHANGE.

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

Student: _____ Date:_____
Signature

Principal: _____ Date: _____
Signature

THIS PLAN REMAINS IN EFFECT FOR THE____-___SCHOOL YEAR WITHOUT CHANGE.

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

Student: _____ Date:_____
Signature

Principal: _____ Date: _____
Signature

Distribution: Original: Secure location accessible by school staff

Original: Scanned and uploaded to SSNET

Original: Scanned and sent to Student Transportation Services

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