PREVALENT MEDICAL CONDITION- GENERAL
PLAN OF CARE

STUDENT INFORMATION		Student Photo
STUDENT NAME:		
Student wears Medical-Alert Bracelet YES NO		
Student receives School Based Nursing Care YES NO		
Date of Birth	Age:	
Teacher	Grade:	☐ **I consent to publicly displaying this photo.**

EMERGENCY CONTACTS in ORDER

Name	Relationship	Phone #
1.		
2.		
3.		
4.		

MEDICAL CONDITION

CONDITION NAME:

CONDITION DESCRIPTION:

MEDICATION/HEALTH PROVIDERS INSTRUCTIONS

Has medication been prescribed to manage this condition? Yes No
Has emergency recovery medication been prescribed? Yes No

If yes, this plan must be shared with your physician and the following section (appendix A) must be completed by a physician.

NCCSA AUTHORIZATION OF PROVISION OF ORAL/TOPICAL Prescription MEDICATION

STUDENT NAME:

Does the student have any other Prevalent Medical Conditions for which there is a Plan of Care?

Yes **No**

If Yes, check all that apply:

- ☐ Anaphylaxis
- ☐ Asthma
- ☐ Epilepsy/Seizure
- ☐ Diabetes
- ☐ Concussion

HEALTH CONDITIONS

Check the appropriate boxes:

- ☐ Spinal Cord Injury
- ☐ Spina Bifida
- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ Multiple Sclerosis
- ☐ Vision Impairment
  Specify: _____

- ☐ Hearing Impairment
- ☐ Narcolepsy
- ☐ Brain Injury
- ☐ Organ Damage
- ☐ Arthritis
- ☐ Muscular Dystrophy

- ☐ Tourette Syndrome
- ☐ Cancer
- ☐ Heart Condition
  Specify: _____
- ☐ Other: _____
- ☐ Other: _____

Medical Devices and Mobility Aids	Medical and Assistive Devices	Assistive Technology and Equipment
☐ Wheelchair or adaptive stroller ☐ Specialized Seating ☐ Back Brace ☐ Orthotics ☐ Crutches/Walker ☐ Other: _____	☐ Prescription glasses ☐ Artificial Limbs ☐ Cochlear Implant ☐ Hearing Aid ☐ Tracheostomy ☐ Shunt ☐ Suction ☐ Oxygen ☐ Tube Feeding Specify: _____ ☐ Other: _____	☐ AAC Device ☐ FM System ☐ Writing Aid ☐ Other: _____ ☐ Other: _____

ADDITIONAL ASSISTANCE

Student requires additional assistance:

- ☐ On a daily/routine basis
- ☐ For specific instances
- ☐ Does not require additional assistance
- ☐ Other: _____

PARENTAL NOTES

STUDENT NAME:	
NCCSA EMERGENCY PROCEDURES	
SIGNS AND SYMPTOMS	
RESPONSE	

INDIVIDUALS with whom THIS PLAN OF CARE WILL BE SHARED

- ☐ **I/we authorize the principal to share the Plan of Care with school staff who are in direct contact with my child.**
- ☐ **I/we are aware that the school will share this Plan of Care with:**
  - **Niagara Children's Centre**
  - **Nursing (if applicable)**
  - **Transportation Provider**

This plan of care remains in effect for the _____ School Year and will be reviewed within the first 30 days of a new school year
If at that time, there are no changes to the student medical history, this information may remain on file.
It is the responsibility of parents to notify the principal if there is a need to change this plan during the school year.

Parent Signature:	Date:
Student Signature:	Date:
Principal Signature:	Date:

Appendix A

AUTHORIZATION OF PROVISION OF ORAL/TOPICAL PRESCRIPTION MEDICATION		
TO BE COMPLETED BY PARENT/GUARDIAN		
STUDENT NAME		
BIRTHDATE		**GRADE**
ADDRESS		**PHONE NUMBER**
PARENT NAME		
HEALTH CARE PROVIDER INFORMATION		
Please review the NCCSA Plan of Care with your healthcare provider.		
Provider Name	Provider Address and Phone Number	☐ Physician ☐ Nurse Practitioner
Special Instructions from Health Care Provider		
Name of Medication		
DATE		
Date prescribed		
Dosage to be provided each time		
Times dosage to be provided		
Method of administration		
Possible side effects		
Storage and safekeeping s		
PARENT/GUARDIAN APPROVAL I hereby request and give permission to NCCSA to provide Oral/topical prescription medication to my child according to NCCSA procedures and the instructions provided. I also affirm that the medication provided is the medication stated on the container provided to the school.		
Signature of Health Care Provider Optional UNLESS medication is rescue medication.		
Signature of Parent/Guardian		DATE: