Confidential

Alliance City Schools

Care Plan

Student's Name: School Year:_____

PPS File #:	Bus #
Date of Birth:	School:
Parent's Name:	School Address:
Address:	School Phone #:
Home Phone:	Grade:
Work Phone:	Homeroom:
Cell Phone:	Diagnosis/Condition:

The following items are to be completed prior to the Care Plan being implemented:

Doctor's order (see attached)	**Date:**_____
Parent Meeting	**Date:**_____
Staff Meeting	**Date:**_____
Supplies	**Date:**_____
Transportation Plan	**Date:**_____

Medical Instruction/Procedure:

Daily Procedure:

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_____

Communication:

_____ Share plan with classroom teacher aide, principal, nurse, health aid and school secretary
_____ Share plan with building staff (music, art, p.e. cafeteria workers etc.).
_____ share plan with transportation staff including: transportation director, bus driver and bus aide.

Transportation:

A.M. and P.M. schedule (See attached) - Route Attached/If needed.

Field Trips:

1. School aid is to accompany student to activities that occur during the school day that are approved events.
2. Follow the Alliance City School district policy concerning medication.
3. Follow Medical/Instruction procedure for care.

In the event of an emergency:

1. If student is unable to communicate or unresponsive dial 911 and transport to emergency room.
2. The bus driver will notify the transportation office of student status.
3. The transportation office will notify the school of the student's status and the school will be responsible for contacting the parent/guardian.
4. If the school is not in session the transportation office will contact the parent/guardian.

Other:

Parent/Guardian Statement: I request this Care Plan to be provided to my child during the current school year. I acknowledge that I am responsible for providing all associated supplies for this procedure. I understand that only treatments that cannot be performed at home will be provided at school. The school district nurse has my permission to contact the physician listed as needed for clarification or to obtain medical information. I agree to notify the school immediately if the health status of my student changes, if we change physicians, if the procedure is cancelled/changed or if my contact information changes.

Signature:_____ Date: _____

Position	Name	Signature	Date