Prince George County Public Schools
Health Services Care Plan

A specialized health care plan should be completed for allergies, asthma, diabetes, head injury, traumatic brain injury, or seizure disorder. For specialized health care plans, contact school nurse or download from the school webpage at www.pgs.k12.va.us.

Student's Name: ______________________________ DOB: ______________ School: ____________

Medication Allergies: ____ School Year: ____________

TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER

Student Condition/Treatment	Description/Information	Comments
Diagnosis, Description of Health Condition, or Chronic Health Problem:		
Is Student Medically Able to Return to School (how many hours per day)?		
Does Student Require an RN/LPN/CNA or Classroom Aide During the School Day?		
Medical Treatments or Procedures During the School Day (such as oxygen, gastrostomy care, urinary catheterization, tube feeding, tracheotomy care, suctioning, nebulizer treatments, chest physiotherapy). Include equipment and/or need for school personnel to be present.		
Food/Latex/Environmental Allergies		
Bathroom or Toileting Needs		

Student Condition/Treatment	**Description/Information**	**Comments**
Special Feeding/Nutrition/Hydration Needs		
List other health care needs such as special precautions in lifting, special techniques for positioning:		
List any Vision or Hearing Needs:		
List any and all Activity Restrictions:		
Special Considerations/Provisions for Field Trips		
Transportation Adaptations/Accommodations needed such as: bus lift, seat belt, wheelchair tie-downs, chest harness, booster seat). ***See additional transportation plan*****.**		
Precautions to Prevent or Treat Emergency or Injury		
OT and/or PT Services needed for School?		
List any Procedures to be Performed by School Personnel (include circumstances and qualifications of persons to perform procedure).		

Student Condition/Treatment	Description/Information	Comments
Is Medication Required to be Administered at School? ** If Yes, an *authorization for Medication Administration at School form must be completed.*		
Does the Student Require Adjustments to the Classroom or School Facility?		
Other:		

Physician Signature ____ Date _____________________

Physician PRINTED Name_______________________________ PHONE__________________

FAX__________________________

To be completed by parent or legal guardian:

Student's Name: ____________________________

♥ **PERSONS TO CONTACT IN CASE OF EMERGENCY: (List in order of priority to be called)**

Name/Relationship ***Phone Number(s)***

1.____
2.____
3.____
4.____
5.____

I, ____,

Parent or legal guardian of _____________________________________ approves this *Health Services Care Plan* for my child. I give permission to share information about my child's medical needs with the school nurse, teachers, principals, office staff, guidance, bus driver/transportation and cafeteria manager as appropriate. I give the principal or his designee the authority to contact my child's physician as needed and to call the rescue squad or take my child to a hospital emergency room in case of emergency.

Parent/Guardian Signature _______________________________________ Date __________________________

Parent/Guardian PRINTED Name
____

PHONE: Home:_______________________________ Work:________________________________

Cell:_________________________________

School Use:
Health care plan information provided by ____ to the following staff:

Names of Persons and Date	*Names of Persons and Date*

Transportation Plan (to be completed by physician and/or school nurse)

Bus #:	Bus Driver:

Student Name:	Homeroom Teacher:

Student Address:	**Home/Cell:**
School:	**Grade:**
Parent/Guardian Name:	**Work # (Father)** **Work # (Mother)**
Receives Medication:	**Possible Side Effects:**
Method of Mobility:	**Method of Communication:**
Student Care Provider/Agency/Daycare/Sitter:	**Address:** **Phone#:**

Transportation Staff Training

Describe Training:

Date Training Completed:

Nurse who Provided Training (Print Name):	Nurse Signature:

Bus Staff Trained:

1.
2.
3.
4.

Adaptations/Accommodations Required:

Bus Lift: Yes or No	Chest Harness: Yes or No	Walks to and from bus: Yes or No
Seat Belt: Yes or No	Booster Seat: Yes or No	Walks up and down stairs: Yes or No
Wheelchair Tie-Downs: Yes or No	Other:	Needs Assistance: Yes or No

Identify equipment that must be transported on the bus and method of securing (including oxygen, life sustaining equipment, wheelchair equipment, communication device, Epi pen, nebulizer, diabetic supplies).

List any Positioning or Handling Requirements:

Behavior Considerations/Describe:

Student Specific Emergency Plan/Procedure: