

Student Name: _____ Grade: _____ DOB: _____

Effective Date: _____ - _____
(*plan in effect one year- may extend through summer)

Male Female

Medical Orders for Special Health Care Needs

Parents must provide all necessary medical supplies to the school. Parents and health care providers work as a team to provide training for school personnel prior to the child entering the class.

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Diagnosis and Description of Medical Concern:

List physical, emotional, developmental, behavioral and/or communication concerns:

List relevant medical history. Include surgery, hospitalizations and allergies:

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Is this student medically able to attend school? Yes No

Full day? Yes No

Comments:

Are there health related expected absences? Yes No

Comment:

Level of participation in PE and/or recess. Full Partial Restricted

Comment:

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Are there any emergency medical interventions needed? Yes No

Describe:

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Is the student able to ride the school bus? Yes No

(Check if needed) transportation aid bus lift seat belt special restraint
 wheelchair tie down space for equipment staff training needs Other:

Specify type of equipment, space, positioning requirements and/or behavior considerations:

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Are procedures required for this student to attend school? Yes No
 Does the student require assistance from additional staff? Yes No
 PRN Unskilled (non-licensed) PRN Skilled (RN or LPN)
 Full time Unskilled Full time Skilled
 Other:

Check all required procedures:

Dietary

- Gastrostomy tube feeding
- Nasogastric tube feeding
- Jejunostomy tube feeding
- Oral Feeding (restrictions)

Respiratory

- Oxygen liters
- Nasal cannula
- Oxygen mask
- Pulse oximetry
- Trach care/suctioning
- Suctioning
- Chest Physiotherapy
- Ventilator

Musculoskeletal

- Cane Crutches Walker
- Orthosis Cast Care
- Wheelchair Prosthesis
- Reposition other

Neuro

- Rectal Diazepam
- Vagal nerve stimulation
- Ventricular Shunt Monitor

Other (describe)

Elimination

- Colostomy Care
- Ileostomy Care
- Diapers or Pullups
- Clean Intermittent Catheter
- Urostomy pouch
- Catheterizing a stoma
- Indwelling urinary catheter (RN or LPN only)

Describe Medical Procedures that are required for this student to attend school (equipment, time intervals, positioning, consider transportation):

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Medication	Dose	Route	Time

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M.D. PRINT _____ **Phone:** _____

M.D. Signature _____ **Date** _____

Other providers	Specialty	Phone

I agree with this plan of care and I give permission for the school to contact any of the above providers.

Parent PRINT _____ **Phone:** _____

Parent (signature) _____ **Date:** _____