Holly Area Schools

General Medical Care Plan

Care plans are valid for one calendar school year and must be updated by a physician with any changes made to medication dose or frequency throughout the school year.

Student's Name: ____ School Year : ___________________

Date of Birth: _____________________ School/Program: ____

Age: _____________ Grade: ________________ Teacher: ____

Page one of this care plan is to be completed, signed and dated by a parent/guardian.
Page two of this care plan is to be completed, signed and dated by the treating physician/ licensed prescriber.
Without **both** signatures this care plan is not valid. Parent/guardian is responsible for supplying all medication & any other supplies required.

Contact Information

First Contact

Name: ______________________________________

Relationship: ________________________________

Phone (1): __________________________________

Phone (2): __________________________________

Second Contact

Name: ______________________________________

Relationship: ________________________________

Phone (1): __________________________________

Phone (2): __________________________________

Third Contact

(If a parent/guardian cannot be reached, must be listed on emergency card)

Name: _________________________________ Phone: ________________ Relationship: ________________

DIAGNOSIS

SIGNS & SYMPTOMS

1.

2.

3.

IF SYMPTOMS OCCUR, DO THE FOLLOWING: ____

____

____

Holly Area Schools

General Medical Care Plan

Student Name: ____________________________ **Date of Birth:** __________ **School Year:** ________

ADDITIONAL NOTES / INSTRUCTIONS: ____
____
____
____

Medication: _______________________________ Dosage: ______________ Route: ______________

Time to be given at school: _________________ If PRN, allowable frequency: _________________

Signs or symptoms to be present if ordered PRN: ____

Medication: ________________________________ Dosage: _____________ Route: ______________

Time to be given at school: _____________________ If PRN, allowable frequency: _________________

Signs or symptoms to be present if ordered PRN: ____

Physician/Licensed Prescriber Name (Print): ____

Phone Number: _______________________________ **Fax Number:** __________________________

Signature: ____ **Date:** ______________________

I agree with this 2 page plan as written and for school staff to share this information with those that need to know and for staff to contact the treating healthcare professional for clarification of this plan, if needed.

☐ YES ☐ NO I have read the attached information regarding section 504 eligibility
☐ YES ☐ NO I wish to be contacted regarding a 504 evaluation

Parent/Guardian Name____

Signature: ____ **Date:** __________________

Holly Area Schools do not have medical personnel present to administer medication / treatment.
If appropriate, please order medication / treatment to be administered at home.