Trinity Classical Academy

Plan of Care

Student:_____Date of Birth: _____

Grade/Teacher:_____Date:_____

Parent/Guardian Information:

Name:_____Home#:_____Work#_____

Mobile#:_____Address:_____

Email:_____

Note: This student has a health condition of which the school staff needs to be aware. The medical diagnosis, care during school hours, emergency care and individual considerations are stated below:

MedicalDiagnosis/Condition:_____
_____
_____
_____
_____

Action Plan for school:

_____
_____
_____

Medications (Dosage and Frequency):

_____
_____
_____

Individual Considerations:

_____
_____
_____

I am the parent/guardian of _____ and request that the Individual Health Care Plan be utilized during school hours. School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this Individual health care plan authorizes the school nurse to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Parent Signature:_____