SCHOOL DISTRICT OF WASHINGTON
HEALTH SERVICES

Date of Plan: _____ **Student Picture**

Care Plan Cover Sheet

This plan should be completed by the student's personal health care team and parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by the school nurse, trained diabetes personnel, and other authorized personnel.

Effective Dates: _____

Student's Name: _____

Date of Birth: _____ Date of Diagnosis: _____

Grade: _____ School: _____ Homeroom Teacher: _____

Physical Condition: ☐ Diabetes type 1 ☐ Diabetes type 2 ☐ Asthma ☐ Bee Sting Allergy
☐ Seizures ☐ Food Allergies ☐ Other (_____)

Contact Information

Mother/Guardian: _____ Address: _____

Telephone: Home _____ Work _____ Cell_____

Father/Guardian: _____ Address: _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:

Name: _____ Address: _____

Telephone: _____ Emergency Number: _____

Other Emergency Contacts:

Name: _____ Relationship: _____

Telephone: Home _____ Work _____ Cell _____

I have reviewed and agree with the medical care plan written on _____ by my child's physician and have provided a copy to my child's school nurse. I understand that if changes are made by the physician to this care plan a new copy will need to be provided to the school nurse.

I also consent to the release of the information contained in this care plan to all staff members, First Student Transportation Company, and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

Self Carry and Administration of Medication
This student will be allowed to carry the medications and supplies needed on his/her person to care for him/her self for the medical condition named on the attached care plan or to keep these medications in his/her backpack, his/her locker, P.E. locker, or car as we consider him/her responsible. He/she has been instructed in and understands the purpose and appropriate method and frequency of the use of these medications and supplies. If he/she feels the need to use the medications or supplies, he/she may use them and then report to the school nurse or office so that the use of these medications and supplies may be recorded and monitored. He/she will be required to demonstrate proper self-administration technique to the school nurse at the beginning of the year and as she deems necessary.

The Washington School District shall incur no liability as a result of any injury arising from the student's self management and administration of the medications and procedures listed in this care plan, and the parents/guardians shall indemnify and hold harmless the district and employees or agents against any claims arising out of the student's self management and administration of medications and procedures. We, the undersigned, absolve the Washington School District of any responsibility in safeguarding our child's medication.

Special Meals
I certify that the above named student needs special school meals (requiring omitted/substitutions) due to the student's medical condition.

Omitted Foods **Substitutions**

Self Medication/Special Meals Approved by:

_____ _____
Physician/Health Care Provider Signature Date

Acknowledged and received by:

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Nurses Signature Date

_____ _____
Nurses Signature Date

Received in Nurses Office on: _____