Other Conditions Support Care Plan

Student Name: **Date:**

Current School Year:

Parent/Guardian: **Parent Home Phone:**

Parent/Guardian: **Parent Home Phone:**

Other Emergency Contact:

Other Conditions	
Other Conditions:	
Medical Conditions:	**Medications/Administration Time/Dosage/Staff Responsible:**
Symptoms	
Observable symptoms possible emergency, side effect of medication:	
Action Plan (including bus instructions)	
Location of medication and key:	
Critical Situation Response Plan (including bus instructions)	
Primary and alternate administrator of medication	
Authorization	
Parent/Guardian Name (please print):	****Only required if medication is being administered or if life threatening condition exists.** Physician Name (Please print)
_____ Parent/Guardian Signature	_____ Physician Signature
Relationship to child:	
Date:	
Designated and trained staff:	
Medical Facilitator Name (if applicable):	