Clearview Public Schools
We All Belong – We All Succeed

316-2 Student Health Support Plan

School Year: 20___ to 20___

School: _____ Homeroom Teacher: _____

Student Information:

Name: _____

D.O.B. _____ Grade: _____

Photo:

Parent/Guardian Name: _____

Phone # _____

Emergency Contact: _____

Phone # _____

Physician: _____

Phone # _____

The information is collected/disseminated in accordance with Sections 32, 33 and 37 of the Freedom of Information and Protection of Privacy Act.

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Description of student's health / medical condition:

Care Needed:

- avoidance strategies
- apparatus or specialized equipment

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Medication Plan

The parent/guardian makes this request in the knowledge that school personnel may have no special training or limited training in the administration of the medication/personal care. The parent/guardian must inform the principal/designate of any changes in the administration of the medication/personal care and a new Student Health Support Plan must be completed.

The parent/guardian will give the school the physician prescribed medication in its original container with the current pharmacy label attached. The medication dose schedule has been planned so that a minimum number of doses will be given at school. Medication/Personal care supplies and refills will be supplied to the school when necessary.

The parent/guardian accepts responsibility to ensure the safe transportation of medications/personal care supplies to the school. The parent/guardian hereby acknowledges that the principal/designate has been authorized to administer the prescribed medication/personal care and hereby releases the principal/designate and Clearview Public Schools from any claim for harmful effects resulting from the administration of the prescribed medication/personal care. The parent/guardian hereby agrees to indemnify and save harmless the principal/designate and Clearview Public Schools from all claims that may result.

_____

This plan is intended for physician prescribed medications including PRN and over the counter medications. For all students with severe allergies and anaphylaxis also complete the Student Anaphylaxis Support Plan form.

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	Medication #1	**Medication #2**
	☐ Monitor ☐ Administer ☐ Pharmacy information sheet is provided	☐ Monitor ☐ Administer ☐ Pharmacy information sheet is provided
Medication Name		
Therapeutic effect(s)		
Possible side effects(s)		
Plan of action for possible side effect(s)		
Dose		
Route of administration (e.g. by mouth)		
Time(s) to be administered		
Start date of medication		
Finish or review date		
Complete During Meeting		
Medication location for administering/monitoring		
Name of staff member administering/monitoring		
Alternative staff member administering/monitoring		
Special instructions		

Parent / Guardian Name (Print)	Parent / Guardian Signature	Date

Principal / Designate Name (Print)	Principal / Designate Signature	Date

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Emergency Care Plan

Signs of an Emergency:

1.
2.
3.
4.

Steps:

1. Call 911
2. Call parents / guardian
3.
4.

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The school personnel listed below have received the necessary training to provide the care described above.

NAME TITLE

☐ All Staff

_____ _____

_____ _____

_____ _____

I have verified that _____ technique employed by the above named persons for the
(Name of service)
care of this student and find it acceptable.

_____	_____	_____
*Authorized health care professional (Print)	Signature	Date
_____	_____	_____
Parent / Guardian (Print)	Signature	Date
_____	_____	_____
Principal (Print)	Signature	Date
_____	_____	_____
Teacher (Print)	Signature	Date
_____	_____	_____
Other (Print)	Signature	Date

Supporting Documentation: _____

**** Note: The signature of an authorized health care professional may be required by the Principal depending on the level of complexity of the service requested.***

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