MEDICAL CONDITION- Tracheoesophageal Fistula
PLAN OF CARE

STUDENT INFORMATION

Student Name _____

Date Of Birth _____ Age _____

Grade _____ Teacher(s)_____

Student Photo

Description of Condition:

_____

_____

_____

_____

_____

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

SUPPORTS

Method of home-school communication: _____

Any other medical condition or allergy? _____

_____

EMERGENCY PROCEDURES

Factors Which May Lead to (condition)

Symptoms of (condition)

❒ Abdominal pain ❒ Feeling weak/ unwell ❒ Muscle pain or cramps ❒ Headache
❒ Vomiting ❒ Dizziness ❒ Shock-like symptoms ❒ Low Blood Sugar
❒ Diarrhea ❒ Low back pain ❒ Loss of appetite
❒ Confusion ❒ Low Blood Pressure ❒ Other _____

Steps to take:

1. Call 9-1-1 Supervise student until emergency medical personnel arrives.
2. Contact parent(s)/guardian(s) or emergency contact
3.

HEALTHCARE PROVIDER INFORMATION

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, administration of medication form is required.
✸This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW			
INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED			
		Yes (Please Initial for each)	No (Please Initial for each)
We, the Parents/Guardians/ Adult Student request the posting of this Individual Plan of Care, including recent colour photo in the:	School Staff Room		
	School Main Office		
	Classroom		
We the Parents/Guardians/Adult Student request the sharing of this plan with individuals which include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff, volunteers, and school bus drivers.			
TRANSPORTATION			
School Bus Driver/Route # (If Applicable)		□ New Plan of Care	□Updated Plan of Care
This plan remains in effect for the 20___— 20___ school year without change and will be reviewed on or before: _____. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year).			
Parent(s)/Guardian(s) Signature :		Date:	
Adult Student Signature:		Date:	
Principal Signature:		Date:	