



INDIVIDUAL HEALTH CARE PLAN

Date Completed _____

School _____ Phone _____

Teacher _____ Grade _____

Release of Information/Consent Signed (copy attached – Exhibit G.1.M-EX3)

STUDENT INFORMATION

Name _____ Date of birth _____

Address _____

M.E.T.# _____ Treaty# _____

MB Health# _____ MHSC PHIN# _____

Parents/Guardians: _____ Phone _____

Primary Caregiver (if other than guardian): _____ Phone _____

Emergency Contact Person _____ Phone _____

HEALTH CARE INFORMATION

Family Physician _____

Address _____ Phone _____

Consulting Physician _____

Address _____ Phone _____

Area of Expertise _____

Other Health Care Professionals _____

Diagnosis _____

Presenting Health Care Needs _____

Plan Participants

Name

Role

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Review Date _____

HEALTH CARE PLAN

The Health/Nursing Care Plan was developed or recommended by:

_____ Date _____
(Health Care Professional)

Health Care Plan (check where appropriate)

_____ is attached and/or _____ is described below

PROCEDURES

(what, where, when, how, supplies/equipment)

PRECAUTIONS

EMERGENCY PROCEDURES

Contact Person _____ Phone _____

Alternate _____ Phone _____

If you see this:

Do this:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

TRANSPORTATION PLAN _____

Name of Adult Accompanying Child _____

RECORD OF PERSONNEL TRAINING

Primary Person trained _____

Date trained _____

Date recommended for retraining _____

Back-up person(s) trained _____

Training Provided by _____

Level and description of training _____

Name of Trainer (please print)

Signature

Date

Name of Principal (please print)

Signature

Date

| | | |
|---------------------------|--|--|
| Adopted September 1, 2009 | | |
|---------------------------|--|--|