CARMAN-AINSWORTH COMMUNITY SCHOOLS

School Based Care Plan

Student's Name _____ Date of Birth _____

Parent or Emergency Contact: _____

Phone: Home _____ Work _____ Cell _____

Physician's Name _____ Phone _____ fax _____

Physician's Address _____

I give my permission for this information to be shared with staff members who are in contact with my child, as deemed necessary by the school nurse or administrator. I also consent to the exchange of information between the school and the physician named on this form pertaining to the diagnosis and health care recommendations.

_____ _____

Parent/Guardian Signature Date

To be completed by physician

Diagnosis:_____

Symptoms of Emergency or Health Concern:

1. _____
2. _____
3. _____
4. _____

Emergency Action Steps:

_____

_____

_____

Additional Instructions or Restrictions:_____

_____

_____ _____

Physician's Signature **Date**

Updated/Reviewed March 2017