Holly Area Schools

General Medical Care Plan

Care plans are valid for one calendar school year and must be updated by a physician with any changes made to medication dose or frequency throughout the school year.

Student's Name: _____ School Year : _____

Date of Birth: _____ School/Program: _____

Age: _____ Grade: _____ Teacher: _____

Page one of this care plan is to be completed, signed and dated by a parent/guardian.
Page two of this care plan is to be completed, signed and dated by the treating physician/ licensed prescriber.
Without **both** signatures this care plan is not valid. Parent/guardian is responsible for supplying all medication & any other supplies required.

Contact Information

First Contact	**Second Contact**
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone (1): _____	Phone (1): _____
Phone (2): _____	Phone (2): _____

Third Contact

(If a parent/guardian cannot be reached, must be listed on emergency card)

Name: _____ Phone: _____ Relationship: _____

DIAGNOSIS

SIGNS & SYMPTOMS

1.

2.

3.

IF SYMPTOMS OCCUR, DO THE FOLLOWING: _____

_____

_____

_____

Holly Area Schools

General Medical Care Plan

Student Name: _____ Date of Birth: _____ School Year: _____

ADDITIONAL NOTES / INSTRUCTIONS: _____

_____

_____

_____

Medication: _____ Dosage: _____ Route: _____

Time to be given at school: _____ If PRN, allowable frequency: _____

Indication for use: _____

Medication: _____ Dosage: _____ Route: _____

Time to be given at school: _____ If PRN, allowable frequency: _____

Indication for use: _____

Physician/Licensed Prescriber Name (Print): _____

Phone Number: _____ Fax Number: _____

Signature: _____ Date: _____

I certify that I have legal authority to consent to medical treatment/care for the student named above, including administration of medications or treatment/care at school. I will not hold HAS Board of Education, its personnel, or employees responsible for complications related to medication or treatment/carer administered in pursuant to this plan. I agree with this 2 page plan as written and for school staff to share this information with those that need to know and I authorize staff to contact the treating healthcare professional for clarification of this plan, if needed.

Parent/Guardian Name_____

Signature: _____ Date: _____

Holly Area Schools is not a medical facility. To the extent practicable and safe for the student, medication should be administered during non-school hours.

5/2024 Office Use: Skyward Alert: ___ Email: ___ Care Plan: ___ Date: _____ Initials: _____