

ESSENTIAL ROUTINE SERVICES and EMERGENCY PLAN

SCHOOL YEAR 2____-2____

PART I – STUDENT INFORMATION

Name of Student: _____ Date of Birth: _____
Year / Month / Day

Medicare Number: _____

School: _____ Home room teacher: _____

Parent / Guardian: _____

Phone: _____ (home) _____ (work) _____ (cell)

Other contact: _____
(i.e. caregiver)

Phone: _____ (home) _____ (work) _____ (cell)

Physician: _____ Phone: _____

Description of student's health/medical condition(s): _____

PART I

PART II – ROUTINE CARE PLAN – complete Part II separately for each service required

Note: Provision of medication to manage an ongoing medical condition is considered an essential routine service

Describe the care required: _____

How often is this required? _____

Student's ability to self-administer / self-care? _____

Any additional instructions: i.e. What apparatus is needed, if any? Care of apparatus. Storage/accessibility of medication.

Parent's responsibilities: _____

School's responsibilities: _____

Student's responsibilities: _____

Please provide any other information that would help us to understand your child's needs.

PART II

Appendix C
ESSENTIAL ROUTINE SERVICES
and EMERGENCY PLAN

Student: _____

The school personnel listed below have received the necessary training to provide the care described on the previous page.

<input type="checkbox"/> All staff	Name	Title
	_____	_____
	_____	_____
	_____	_____
	_____	_____

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

Authorized health care professional: _____
signature **Date:** _____
year / month / day

Title: _____

OR

Parent / Guardian: _____
signature **Date:** _____
year / month / day

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.

Student: _____

PART III – EMERGENCY CARE PLAN – complete only if an emergency plan is required

This part is to be completed by the school in collaboration with the parent.

Parent's responsibilities: _____

School's responsibilities: _____

PART III

PART IV – SIGN-OFF

I have read and understand the *Essential Routine Services and Emergency Plan* agreement and agree to the sharing of information relevant to the service requested with those persons who must know in order to provide the service.

Student (16 years and older): _____ Date: _____
signature year / month / day

I hereby request and authorize school personnel to provide the care described above to my child. I understand the designated persons have no medical qualifications and will perform the requested service in good faith and within the scope of the training received in accordance with this agreement.

In the event of an emergency, I authorize school personnel to administer the medication(s) specified in this agreement and provided by me, and to obtain suitable medical assistance. I agree to assume responsibility for all costs associated with medical treatment and transportation.

I hereby acknowledge my responsibilities, as set out in this agreement and in Policy 704 - [Health Support Services](#), and agree to carry these out to the best of my ability.

I agree to notify the school in writing of any changes to the information provided on this form.

I agree that the information provided on this form will be shared on a need-to-know basis with anyone who will be involved in the care of my child on behalf of the school.

I agree that the principal or his/her designate may contact my child's physician in the event of a medical emergency or should he/she require clarification about the school's responsibilities as set out in this plan.

Yes No

Parent/Guardian: _____ Date: _____
signature year / month / day

I hereby acknowledge and accept my responsibilities and those of my staff, as set out in this agreement.

Principal: _____ Date: _____
signature year / month / day

This procedure/care is essential and must be provided during school hours. Yes No

I have reviewed the *Essential Routine Services and Emergency Plan* for _____
and feel it is appropriate for his/her needs. name of student

Authorized health care professional: _____ Date: _____
signature year / month / day

ANNUAL REVIEW

Note: if the requirements of the service requested have changed, complete a new *Essential Routine Services and Emergency Plan* form. If there are no changes, use this sign-off sheet to confirm the plan has been reviewed with the parent.

This plan remains in effect for the 2_____-2_____ school year without change.

Parent/Guardian: _____
signature

Date: _____
year / month / day

Principal: _____
signature

Date: _____
year / month / day

This plan remains in effect for the 2_____-2_____ school year without change.

Parent/Guardian: _____
signature

Date: _____
year / month / day

Principal: _____
signature

Date: _____
year / month / day

This plan remains in effect for the 2_____-2_____ school year without change.

Parent/Guardian: _____
signature

Date: _____
year / month / day

Principal: _____
signature

Date: _____
year / month / day

This plan remains in effect for the 2_____-2_____ school year without change.

Parent/Guardian: _____
signature

Date: _____
year / month / day

Principal: _____
signature

Date: _____
year / month / day