INDIVIDUAL CARE PLAN

This form shall be completed for each student who has one or more acute or chronic medical conditions such that additional supports, accommodation or assistance may be required.

Child's Full Name:		Photo of Child
Child's Date of Birth:		
Key Parent Contact:		
Key Contact Telephone:		
Date Initiated:		
Date Reviewed:		
Reviewed By:		
Staff Key Contact[1]:		
Classroom:		

CARE CONSIDERATIONS: Attach Relevant Sections (as checked) to this front page. Do not attach sections that do not apply.

1. ALLERGIES	2. ANXIETY[2] / MH	3. BREATHING[3]	4: CANCER	5: DIABETES	6: DIGESTIVE[4]
7: HEART[5]	8: MOBILITY[6]	9. SEIZURES[7]	10. SERVICE DOG	11: MEDICATIONS	12: DEVICE / TECH
13: OTHER:			Date Reviewed:		

The Individual Care Plan is in place to attend to accommodations due to medical/health concerns and may supplement, but should not be confused with, an Individualized Program Plan. It is possible for a student to have and ICP and an IPP, or neither, or both.

DURATION:

A. PERMANENT	Condition is ongoing and will impact the student over the course of their academic career.			
B. PERMANENT, EPISODIC	Condition includes periods of good health interrupted by periods of illness or disability.			
C. TEMPORARY	Anticipated Duration:		To:	

OVERALL MEDICAL SEVERITY:

MILD. Few to no accommodations.	MODERATE. Some accommodations.	SEVERE. Normal functioning impacted.

LEARNING ACCOMMODATIONS IN PLACE:

INDIVIDUAL PROGRAM PLAN (IPP) REQUIRED[8]	IPP NOT REQUIRED

HEALTH CARE PROFESSIONAL INFORMATION (OPTIONAL – AS REQUIRED):

	Family Physician
	Psychiatrist
	Psychologist
	Other

[1] The staff member assigned as the most responsible person for this student's well-being.

[2] Clinically diagnosed Anxiety Disorder for which a remediation plan is required; Mental Health (MH) concerns present.

[3] Includes respiratory challenges (i.e. Asthma, Cystic Fibrosis).

[4] Includes Inflammatory Bowel Diseases (i.e. Crohn's & Colitis, Celiac).

[5] Includes heart and blood vessel concerns (i.e. Anemia, Hemophilia, Postural Orthostatic Tachycardia)

[6] Includes Arthritis and Rheumatologic Conditions: (i.e. Fibromyalgia, Henoch-Schonlein Pupura (HSP), Lupus). Also includes bone and muscle concerns (i.e. Scoliosis, Muscular Dystrophy).

[7] Epilepsy and Seizure Disorders.

[8] An Individual Care Plan is NOT an Individual Program Plan (IPP) but should inform decisions made on a student's IPP.

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This form shall be completed for each student who has one or more acute or chronic medical conditions such that additional supports, accommodation or assistance may be required.

Contact this person First:

Name:		Home:	
Relationship:		Work:	
Can pick up / remove from school? [Yes] [No]		Cell:	

Contact this person Second:

Name:		Home:	
Relationship:		Work:	
Can pick up / remove from school? [Yes] [No]		Cell:	

Contact this person Third:

Name:		Home:	
Relationship:		Work:	
Can pick up / remove from school? [Yes] [No]		Cell:	

Contact this person Fourth:

Name:		Home:	
Relationship:		Work:	
Can pick up / remove from school? [Yes] [No]		Cell:	

Student's Primary Home Address

Student's Alternate Address (i.e. based on Custody Agreement)

Days / Times at this address:

Other Relevant Information:

Privacy Disclosure: We are collecting personal medical information about your child to determine how best to meet your child's specific personal care requirements. Information collected is provided to appropriate staff on a need-to-know basis, and to people who are working with your child and providing care. All information collected will be held pursuant to the *Education Act* and accompanying regulations. We will not disclose, to any other person or organization, except as authorized by the Freedom of Information and Protection of Privacy Act. Should you have questions about the collection and use of this information, please contact your child's Principal or the Director of Student Services at Parkland School Division (780) 963-4010.

THESE FIRST PAGES (CONTACT INFORMATION) MUST BE ATTACHED TO ANY RELEVANT SECTIONS (BELOW)

11. MEDICATIONS

This form shall be completed for each student who has one or more acute or chronic medical conditions such that additional supports, accommodation or assistance may be required.

Is it the student's responsibility to come to receive medication?	No	Yes

Medication:			
Medication is to be:	☐ Administered only by staff member	☐ Self-Administered under supervision.	☐ Self-Administered
☐ Used when the following symptoms appear:			
Start/End of Prescription:			
Dosage Schedule:			
Person responsible for administering medicine:		Alternate Person:	
Location of Storage:			
☐ Attach a copy of the child's prescription to this form. ☐ Attach pharmacist printout of side-effects if any.			

With respect to the specific medication listed above, I hereby give my permission for Parkland School Division staff to administer the medication as prescribed. I make this request in the knowledge that school personnel have no special training or limited training in the administration of the medication. I acknowledge that it is my responsibility to inform the Principal of any changes in the administration of the medication. I acknowledge that any new request/authorization form for new medication, or for an alteration to the above, must be completed and given to the principal. In addition, I accept responsibility to ensure the safe transportation of these medications to the school. I hereby acknowledge that at my request the principal or designate has been authorized to administer the prescribed medication. I hereby release the principal and/or designate, my child's school, and Parkland School Division from any claim for harmful effects resulting from the administration of the prescribed medication, and I hereby agree to indemnify and save harmless the principal and/or designates and Parkland School Division from all claims that may result therefrom.

Printed Name of Key Responsible Parent	Signature of Key Responsible Parent

COMPLETE A SEPARATE FORM FOR EACH MEDICATION