

All Saints Catholic School

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Care Plan for Students with Special Health Needs, 2009-10

Name of Student _____ Grade _____

Teacher(s) _____

Diagnosis and age of onset _____

Please list all medications the student is on including doses and times:

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

Physician's name _____ Tel. _____

To be completed by the physician:

Please list any limitations to physical activity:

Please list special daily needs other than medication (i.e. blood sugar testing, peak flow, etc.)

1. _____
2. _____
3. _____

Please list steps to be taken in case of emergency:

Physician's signature _____ Date _____

Parent's signature _____ Date _____