UNION COUNTY PUBLIC SCHOOLS
PLAN OF TREATMENT

Student's Name & Address Parent/Guardian:_____ Phone:_____ FAX:_____ DOB: _____ Sex:_____ Pertinent Diagnoses: Date of onset:_____ Surgical Procedures Related to Care: Date:_____	School Name & Address: Phone:_____ FAX: Teacher's Name: Medications: Dose/Frequency/Route <u>Allergies:</u> <u>Mental/Emotional Status:</u> ☐ Able to be responsible for self care ☐ Needs assistance with care ☐ Unable to participate in care
Functional Limitation/Requirements ☐ no restrictions ☐dyspnea ☐ partial wt. bearing ☐ bowel/bladder ☐ hearing ☐ wheelchair (incontinence) ☐ speech ☐ walker ☐ contractures ☐ vision ☐ crutches ☐ paralysis/paresis ☐ exercises ☐ other prescribed	Goals:

<u>Physician's Orders For Procedures/Treatments/Observations</u>:

Physician's Name & Address:

I certify that the above services are required and are authorized by me with a written plan of treatment which will be periodically reviewed by me. This patient is under my care and is in need of these services. I authorize school staff to administer treatments and medications during school hours as appropriate.

Phone Number:_____ Physician's Signature:_____ Date:_____
FAX Number:_____