WAYNE RESA Leading... Learning for All | SERVICE LEADERSHIP COLLABORATION EXCELLENCE

Caring for Students (C4S) Medical Plan of Care (POC)

Student Demographics					
District:					
Last:	First:	M:	SFX:	ID:	
School:		Grade:		Birth Date:	

Parent Comments

District/Physician/Agency/Other Comments

POC Participants			
Name	**Title/Relationship**	**Contributed to the POC**	**Attended POC Meeting**
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

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Caring for Students (C4S) Medical Plan of Care (POC)

Plan of Care Details	
Date:	**Type:**
Purpose:	
Health Condition/Reason for Treatment/ or Diagnosis (when applicable)	
Descriptions of the conditions impacting the student's overall performance	
Short-Term Goals	
Long-Term Goals	
Plan for Reaching Goals	

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Caring for Students (C4S) Medical Plan of Care (POC)

Planned Direct Medical Interventions and Supports

Service Type (medical providers)	Service Duration (start date/end date)	Minutes/Hours (low to high)	Sessions (low to high)	Frequency (week, month)	Delivery Mode (Direct, Direct/Consult)
☐ Social Worker					
☐ Psychologist					
☐ Professional Counselor					
☐ Board Certified Behavioral Analyst					
☐ Marriage & Family Therapist					
☐ Nurse		As Needed	As Needed	As Needed	Direct

Personal Care

Is the severity of the student's condition such that it requires daily hands-on monitoring or cueing to complete daily living tasks that they would do by themselves if not for their medical or behavioral condition?

☐ **YES** ☐ **NO**

Personal Care Authorization

☐ Assistance with self-administered medications	☐ Health-related functions through hands-on assistance, cueing, or monitoring.
☐ Other (i.e. monitoring for seizures/glucose levels)	☐ Redirection and Intervention for Behavior

Coordination of Provider/Agency Services (if applicable)

Provider:	Process for Coordination of Service:
Agency:	Process for Coordination of Services:

Anticipated Needs and Other Comments:

Caring for Students (C4S) Medical Plan of Care (POC)

Medically Qualified Clinician/Provider Signature	
☐ I have reviewed the student's Medical Plan of Care (POC) ☐ When applicable, I will inform the student's primary care provider (PCP)/ case manager (nurse, therapist, etc.) of the student's medical condition on a regular basis.	
Name:	**Title:**
Signature:	**Date:**

Parent/Guardian Informed Consent	
☐ I have received a copy of the Plan of Care (POC). ☐ I consent to the planned interventions/treatments in the medical plan of care. ☐ I do not consent to the planned interventions/treatments in the medical plan of care.	
Name:	
Relationship:	
Signature:	**Date:**