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

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

Parent Comments	☐ Attached ☐ MISTAR

District/Physician/Agency/Other Comments	☐ Attached ☐ MISTAR

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

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Supporting Medical Treatment Plan			☐ **Attached** ☐ **MISTAR**
Medical Management Plan ☐	**Individualized Healthcare Plan** ☐	**Other:** ☐	

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

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Planned Direct Medical Interventions and Supports	☐ **Attached**	☐ **MISTAR**

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 and Family Therapist					
☐ Nurse		As Needed	As Needed	As Needed	Direct

Personal Care	☐ **Attached**	☐ **MISTAR**

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	☐ **Attached**	☐ **MISTAR**

☐ 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)	☐ **Attached**	☐ **MISTAR**

Provider:	Process for Coordination of Service:
Agency:	Process for Coordination of Services:
Anticipated Needs and Other Comments:	

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Medically Qualified Clinician/Provider Signature	☐ **Attached** ☐ **MISTAR**
☐ 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	☐ **Attached** ☐ **MISTAR**
☐ 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:**