**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

Allergies:
Mental/Emotional Status:
☐ 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 (incontinence) | ☐ hearing | ☐ wheelchair |
| | ☐ speech | ☐ walker |
| ☐ contractures | ☐ vision | ☐ crutches |
| ☐ paralysis/paresis | ☐ exercises prescribed | ☐ other |

Goals:

Physician's Orders For Procedures/Treatments/Observations:

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:_____
FAX Number:_____

Physician's Signature:_____ Date:_____