IMMANUEL CHRISTIAN SCHOOL

GENERIC CARE PLAN

STUDENT: _____ DOB: _____

MEDICAL DIAGNOSIS: _____
(Medication that needs to be administered during school hours requires a medication authorization form to accompany this form.)

PHYSICAL RESTRICTIONS: _____
_____

Medication will be needed during the school day: Yes___ No ___
Please list medications and dosage/administration instructions:

_____
__ _____
_____

All medications require a medication authorization form to be completed by a physician.
Medications must be in original pharmacy labeled containers with student's name written on them in permanent marker. *Please note expiration dates!

FURTHER INFORMATION ABOUT THIS CONDITION:* Information that may be necessary for a caregiver (may be medically untrained school personnel or volunteer) in an emergency situation. _____
_____
_____
_____
_____
_____

Physician Permission/ Signature

_____ _____
Physician name (printed) **Physician's signature**

_____ _____
Date **Physician's phone #**

Parent/Guardian Permission/ Signature

This care plan is appropriate for my child. I agree to release, indemnify, hold harmless ICS and any of their officers, staff members, or agents from law suits, claim expense, demand or action, etc., against them for helping this student with their medication providing ICS personnel are following physician instructions as written above. ICS has my permission to contact my child's physician or the physician's designee regarding my child's condition.

Parent/Guardian Signature **Date**