Galena Park ISD

Plan of Care for Treatments/Procedures

The school needs a current diagnosis along with a plan of care during school hours.

Please list all medications along with the times they are administered.

Date: _____

Student name: _____Date of Birth: _____

Diagnosis: _____

Medications: _____

_____

_____

' R F W R U ¶ V R U G H U V I R U V F K R R O K R X U V : D W P H Q W V G X U L Q J V

_____

_____

_____

Recommendations: _____

_____

_____

Limitations: _____

_____

_____

3 K \ V L F L D Q ¶ V S U L Q W H G Q D P H _____

3 K \ V L F L D Q ¶ V V L J Q D W X U H

3 D U H Q W ¶ V _____ Date: _____

Parent Printed Name: _____