



*"We Inspire and
Empower Learners"*

NORTH ROYALTON CITY SCHOOLS

6579 Royalton Road
North Royalton, Ohio 44133

GENERAL HEALTH CARE PLAN PACKET

Dear Parent/Guardian:

You have indicated that your child has _____. Please complete the attached **GENERAL HEALTH CARE PLAN** and return it as soon as possible to the school's clinic. The information will only be shared with the appropriate personnel. This information that you provide will help to ensure the health and safety of your child.

If your child requires medication for this condition during school hours, please also complete the **Administration of Medication Request Form** and return it as soon as possible. All medications must be delivered with completed form by an adult.

If your child is no longer under the care of a physician for this condition, please handwrite a note and forward it to the school clinic as soon as possible. This will allow us to remove the medical alert from your child's record.

Please inform the school's clinic of any changes in your child's health condition or medication schedule.

Thank you,

Carolyn Baetjer, R.N., BSN, NCSN
District Health Coordinator
North Royalton City Schools
14709 Ridge Road
North Royalton, Ohio 44133
440.582.9067



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NORTH ROYALTON CITY SCHOOLS GENERAL HEALTH CARE PLAN * CONFIDENTIAL *

Form with fields: Addendum Attached, Received by, Date

This form is intended to be used as an addendum to a Section 504 plan, if necessary, or for those students who need general health-related support in the school environment but are not eligible under Section 504. Use of this form for 504-eligible students does not eliminate the need for a 504 plan (DSE-504D).

STUDENT INFORMATION table with fields: Student Name, Grade, Age, School, Date of Birth, Medical Diagnosis

MEDICAL INFORMATION table with fields: Medical History, Current Medications, Allergies

SPECIAL NEEDS and/or RESTRICTIONS DURING SCHOOL HOURS section with fields: Needs, Restrictions, Physician's Signature, Telephone, Date, Physician's Name Printed

I give permission for school personnel to follow this plan, administer medication (if any) and care for my child and contact my physician if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this General Health Care Plan for my child. I also consent to the release of the information contained in this General Health Care Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

Form with fields: Parent/Guardian(s) Signature, Date, Parent/Guardian(s) Name Printed