Dream • Learn • Grow
Bloorview
SCHOOL AUTHORITY

Management of Medical Concerns

Revised Sept 2020
Form # **MM.01-06**

Student Photo

STUDENT NAME: _____ CLASSROOM: _____

MEDICAL DIAGNOSIS: : _____ DATE EFFECTIVE: _____

Student wears a medical alert: ☐ Yes ☐ No

Nature Of Treatment	Signs & Symptoms	Facilitating Daily/Routine Management At School
		If additional space is required, please use the reverse side.

I/We authorize the Principal or Principal Designate to share this plan of care with school staff who are in direct contact with my/our child. For example, the classroom teacher, educational assistants, rotary teachers, occasional staff, appropriate Holland Bloorview Kids Rehabilitation Hospital staff, and volunteers.

Other individuals to be contacted regarding this plan of care: _____

This plan remains in effect for the completion of the school year and will be reviewed annually. It is the parent's responsibility to notify the principal if there is a need to change this plan of care for Management of Medical Concerns during the school year.

_____ _____

Signature of Parent/Legal Guardian *Signature of Health Care Professional (Physician, Nurse Practitioner)*

_____ _____ _____ _____

Phone Number(s) *Date* *Phone Number(s)* *Date*

Personal information contained on this form is collected pursuant to the *Education Act* and the *Municipal Freedom of Information and Protection of Privacy Act*. Questions about the collection and the use of this personal information should be directed to, Bloorview School Human Resources, at 416 424-3831.