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: _____

_____

_____

Doctor's orders for treatments during school hours:

_____

_____

_____

Recommendations: _____

_____

_____

Limitations: _____

_____

_____

Physician's printed name: _____

Physician's signature: _____ Date: _____

Address: _____ Phone: _____ Fax: _____

Parent's signature: _____ Date: _____

Parent Printed Name: _____