Individualized Student Care Plan

Student Name: .
Student DOB:
Parent/Guardian:
Day/Work Phone:
Healthcare Provider:
Healthcare Provider Phone:

School:
Case Manager/Responsible Party:
Plan Start Date:
Plan End Date:
Special Ed. Disability:
Qualified Professional/Care Supervisor Name & Title:

ASSESSMENT DATA *(evaluation results would indicate need of para support for what reasons?)*

Personal Care Assistance is needed for: ☐ Grooming ☐ Dressing ☐ Personal hygiene ☐ Transfers ☐ Mobility ☐ Positioning ☐ Eating

☐ Diet monitoring ☐ Toileting ☐ Medication monitoring ☐ Behavioral Support ☐ Other Health-Related tasks

HISTORY/DIAGNOSIS *(what is the medical diagnosis and/or student's history that would support need for para?)*	*SPECIFIC STUDENT NEEDS and PROCEDURES* *(what event will/could occur during the school day with this student and what is the specific action[s] the para needs to take to achieve the desired outcome? Needs to be specific and number list if necessary; all areas marked from Assessment Data above should be covered; may need to continue on back)*	*EMERGENCY INSTRUCTIONS and PHONE NUMBERS* *(phone numbers of nurse, 911, social worker, or anyone else in the building that would give immediate assistance if needed and what should the para do to give the student best emergency care?)*

Signatures of Care Plan team: *Title* *Date:*

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