TRUMBULL COUNTY EDUCATIONAL SERVICE CENTER

TCESC PRESCHOOL PROGRAM
HEALTH CARE PLAN

Route to:____Nurse _____Teachers _____Principal _____District Rep.

Student's Name:_____ Date of Birth:_____

Address:_____

Diagnosis:_____

Phone:_____ Plan Date:_____

General Medical Information

Brief medical history: _____

_____

_____

Special Health Care Needs of the Child: _____

_____

_____

Name of Student's Physician:_____ Phone:_____
Address:_____

Name of Student's Dentist:_____ Phone:_____
Address:_____

Surgeries:_____

Medications/Dosage:_____

Prescribed for:_____

Any Side Effects?:_____

Allergies:_____ Demonstrated by (hives, etc):_____

Any special feeding/eating considerations:_____

Special Utensils:_____

TOILETING

_____Independent _____Initiates _____Needs help with fasteners
_____Needs monitored while transferring _____ Needs help maintaining seated position
_____ Needs help wiping _____Wear diapers _____Catheterized; how often

SENSORY

Do you suspect your child has a vision problem? _____yes _____no
Do you suspect your child has a hearing problem? _____yes _____no
Primary means of communication: _____Verbal _____Signing _____Gestures
_____Augmentative Device

THERAPIES

What therapies does your child receive outside of school? ___OT ____PT _____Speech
Where does your child receive these therapies?_____

Therapist Name:_____

Are there any physical needs we have not covered?____ Yes _____No
Are there any restriction or limitation to be noted ? _____Yes _____No
Please Note (braces,etc) :_____

Transportation Needs :_____

The following evacuation procedures will be utilized in case of emergency.

1. In service staff as to how to remove child from building, bus, etc…
2. Practice evacuation procedures
3. Any special instructions_____

_____

Helpful hints:_____

Is there an Emergency Plan for this child? _____Yes _____No

6000 Youngstown Warren Rd. Niles, Ohio 44446
Phone: 330 505-2800 Fax: 330 505 2814