

INSTRUCTIONS TO COMPLETE AN INDIVIDUAL HEALTH CARE PLAN (IHP)

Section I: Identifying Information—Provide detailed information

- a. **Student's Information**
- b. **Parents/Guardians Information**
- c. **Physician's Information**
- d. **Hospital Information**
- e. **School Nurse Information**

Section II. Medical Overview—Complete the questions on the lines provided

- a. **Medical Condition:** include ALL medical conditions (i.e., food allergies, asthma)
- b. **Medications:** include ALL medications
- c. **Side Effects:** include ANY side effects from medications
- d. **Necessary Health Care Procedures at School**
- e. **Healthcare Plan for Period:** include start and end date

Section III. Other Information—add in optional information that has not been covered in the IHP

Section IV. Background Information/Nursing Assessment—provide detailed information on the following, if necessary check the box and attach additional sheets.

- a. **Medical History:** description of the child's past allergic reactions, include triggers, signs/symptoms, and the child's verbal description
- b. **Social/Emotional Concerns:** describe how the medical conditions can cause social and emotional response in the child and require the need for support
- c. **Academic Achievement:** describe academic achievements and/or challenges that can be affected due to the medical condition(s)

Section V. Interventions— Provide detailed information on the following, if necessary check the box and attach additional sheets.

- a. Medications:** List medications or refer to Emergency Care Plan (ECP) and/or Food Allergy Action Plan (FAAP)
- b. Diet:** List meal substitutions; note if parent/guardian is requesting the school provide school meal substitutions then a written physician statement is necessary
- c. Transportation:** List the student's form of transportation to/from school: bus, car, walker; Note: it is highly recommended that no eating/drinking is allowed on the bus
- d. Classroom School Modifications:** Consider seating assignments; handwashing schedules/procedures; cleaning procedures for chairs/desks
- e. Equipment:** Remember emergency medications, first aid kit, cleaning supplies, snacks
- f. Safety Measures:** Attach Emergency Care Plan (ECP), Food Allergy Action Plan (FAAP), 504 Plan/IEP
- g. Substitute Backup Staff:** It is highly recommended that all substitute staff be included in training
- h. Possible Problems:** i.e., all staff training; staff/parent/guardian resistance with procedures; understanding that food allergies are life-threatening
- i. Training:** Consider annually/biannually; do the parents/guardians want to participate

Section VI. Individual Health Plan Review— Document Next Review Date

Section VII. Documentation of Participation— Have ALL school staff members who are identified as responsible parties read, review and sign the IHP.

Section VIII. Parent/Guardian Authorization for Special Health Services— provide child name, DOB, and parents/guardians signature/date.

INDIVIDUAL HEALTH PLAN (IHP)

Section I: Identifying Information

Student's name _____ **Birth date** _____ **Age** _____

School _____ **Grade** _____

PARENTS/GUARDIANS

Mother's name _____

Mother's address _____

Mother's home phone _____ Work _____ Cell _____

Father's name _____

Father's address _____

Father's home phone _____ Work _____ Cell _____

PHYSICIAN

Physician name _____ Phone _____

Physician address _____

HOSPITAL

Hospital emergency room _____ Phone _____

Hospital address _____

Ambulance service _____ Phone _____

SCHOOL

School nurse _____ Phone _____

Section II: Medical Overview

Medical condition _____

Any known allergies _____

Medications _____

Possible side effects _____

Necessary health care procedures at school _____

Healthcare plan for period _____ to _____

Section III: Other Important Information

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Section IV: Background Information/Nursing Assessment

Brief Medical History	<input type="checkbox"/> Check if additional information is attached.
Social/Emotional Concerns:	<input type="checkbox"/> Check if additional information is attached.
Academic Achievement	<input type="checkbox"/> Check if additional information is attached.

INDIVIDUAL HEALTH PLAN (IHP)

Section V: Interventions

Medications: See Emergency Plan and Medication Authorization Forms.		
<input type="checkbox"/> Check if additional information is attached.		
Diet		
<input type="checkbox"/> Check if additional information is attached.		
Transportation:		
<input type="checkbox"/> Check if additional information is attached.		
Classroom School Modifications:		
<input type="checkbox"/> Check if additional information is attached.		
Necessary Equipment/Supplies	Provided by Parent/Guardian	Provided by District
Safety Measures: See attached Emergency Action Plans.		
<input type="checkbox"/> Check if additional information is attached.		
Substitute Backup Staff (when primary staff not available): ECP/FAAP or IEP will be in the substitute folder. Substitute teachers will be trained in the recognition of allergy symptoms, administration of epinephrine auto-injectors.		
Possible Problems to be Expected		
Training: All staff at _____ School will participate in training annually and as needed that addresses recognizing signs/symptoms of an allergic reaction, administering epinephrine auto-injectors, cross-contact, and understanding related social-emotional issues. All staff training will be documented.		
New staff will be trained prior to working with students during the school day.		

Section VI: Individual Health Plan Review

Next review date of Health Care Plan: As needed, when requested by any team member.

Section VII: Documentation of Participation

We the undersigned staff of the _____ School District, have read and understand the Individual Health Plan and agree with its contents and attachments. The parents/guardians will be notified by a staff member to be identified by the school nurse or school counselor, if there is a change or cancellation of a procedure.

SIGNATURE

DATE

School nurse _____

Documentation of teacher, teacher assistant, and office staff reviewing and understanding the contents of the IHP its attachments will be documented by the school district.

VIII: Parent/Guardian Authorization for Special Health Services

We (I) the undersigned who are the parents/guardians of (child) _____ (date of birth) _____ have participated in the development of this Individualized Health Plan. We approve this Individualized Health Plan and the attachments.

We (I) understand that (a) qualified designated person(s) will perform the health care service. It is our understanding that in performing this service, the designated person(s) will be using a standardized procedure.

We (I) will notify the school immediately if the health status of child changes, we change physicians, or there is a change or cancellation in procedure.

We (I) agree to provide the following, _____

PARENT/GUARDIAN SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE

DATE