Individualized Health Care Plan **Student Name:** **School Year:**

Other Medical Condition Individualized Healthcare Plan

SECTION I			
Student:			**WT:** / **HT:**
Grade:	**D.O.B**	**Any Known Allergies**	
School:			
District:		**Bus (check one) ☐YES ☐NO**	
		Bus #AM	**Bus #PM**
School Nurse:		**Pager #**	**Cell #**
Medication taken at home: (please list)			

Contacts			
Mother	**Home #**	**Work #**	**Pager/Cell #**
Father	**Home #**	**Work #**	**Pager/Cell #**
Guardian/Custodian	**Home #**	**Work #**	**Pager/Cell #**
Home Address		**City #**	**Zip**
Emergency Contact (Relationship)		**Home #**	**Work #**
Physician		**Phone #**	**Fax#**
Physician Address		**City**	**Zip**

Date	Special Notes

Individualized Health Care Plan **Student Name:** **School Year:**

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SECTION II: EMERGENCY ACTION PLAN

IF YOU SEE THIS…	DO THIS…

***ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION SIGNED BY THE PRESCRIBER**

School Nurse Use Only

*Medication and/or Magnet	Expiration Date	Self-Carry?	Location of Medication and/or Magnet

Notes /Special Instruction_____

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SECTION III:	
Brief description of medical condition:	
Avoid circumstances that may lead to potential emergency:	
CLASSROOM:	**PHYSICAL EDUCATION:**
FIELD TRIPS:	**BUS TRANSPORTATION:**
EMERGENCY DRILLS AND SCHOOL CRISIS EVENTS	**OTHER:**
□During Crisis Event Follow School Safety Plan. □ School Nurse will secure medications in accordance with school safety plan □ In event of building evacuation, School Nurse or Medication Assistant will evacuate with medications. □ In event of building evacuation, School Nurse Location is: □ Student requires assistance to evacuate building? □ No □ Yes ➢ If "yes", describe:	After School Care: Extracurricular Activity:

Individualized Health Care Plan **Student Name:** **School Year:**

Written Notes/Addendum to Plan of Care

DATE		PARENT/ GUARDIAN INTIALS (if needed)

I understand and agree with this Individualized Healthcare Plan.

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency.
I give permission for the release of my child's medical information, in the event of an emergency.

Signature of Parent or Guardian **Date**

Signature of School Nurse **Date**

Individualized Health Care Plan **Student Name:** **School Year:**

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name: _____ **School:** _____

Date of Birth: ____/____/_____ Age: _____ Grade: _____ Teacher: _____

☐ **No known drug allergies---if drug allergies list:** _____ Weight: _____pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ **Dosage:** _____ **Route:** _____

Frequency/Time(s) to be given: _____ **Start Date:** ___/___/___ **Stop Date:** ___/___/___

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes ☐ No ☐

Is self- medication permitted and recommended? Yes ☐ No ☐

If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.

Do you recommend this medication be kept "on person" by student? Yes ☐ No ☐

Printed Name of Licensed Healthcare Provider: _____ **Phone:** ( ) _____-_____ **Fax:** _____-_____

Signature of Licensed Healthcare Provider: _____ **Date:** _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ **Date:** ___/___/___ **Phone:** ( ) _____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ **Date:** ____/____/_____ **Phone:** ( ) _____-_____

Individualized Health Care Plan **Student Name:** **School Year:**

Communication of the Individualized Health Care Plan

SECTION IV:

☐ Check this Box if Read Receipt is used to communicate Individualized Health Care Plan to staff.
* Nurse to attach Read Receipt document to this packet.

☐ Check this box if staff receives and signs below for Individualized Health Care Plan.

I have read and understand this student's Individualized Healthcare Plan, and have printed a copy to be maintained in my confidential folder/binder of instructions for substitute teachers.

I have been given the opportunity to ask questions.

I understand my role in addressing this students medical needs.

I am aware the school nurse is available to help clarify any future concerns.

Employee Name	Employee Signature	Position	Date