Individualized Healthcare Plan

Identifying Information

Student Name: _____DOB:_____

Teacher/Grade: _____

Mother's Name: _____Phone#_____

Father's Name: _____Phone#_____

Physician

Physician: _____ Office #: _____

Physician Address: _____

Hospital of Choice: _____

Emergency Contact (in addition to or different from above)

Name: _____ Relationship: _____

Phone #: _____

Name: _____ Relationship: _____

Phone #: _____

Medical Overview

Circle Medical Condition(s):

Asthma **Food Allergy** **Environmental Allergy** (ex: bee stings) **Diabetes**

Cardiac **Seizure** **Other:_____**

This IHP is for one school year. I, the parent/guardian of _____ give consent to release the information contained in the IHP to all staff members who will care for my child or who may need to know this information to maintain my child's health and safety. I will notify the school nurse immediately if the health status changes, there is a change of physicians, or there is a change or discontinuation of medications or procedures. I agree to provide medical equipment, supplies, and medication as needed for the care of my child. By signing one time below, and initialing each needed page, I am in agreement with all instructions, treatments, procedures, medications, & action plans attached.

Parent/Guardian Signature/Date: _____

Parent/Guardian initials: _____

Authorization for Administration of Medication

Student Name/Grade: _____

Prescription Medication

(To be Completed & Signed by Health Care Provider)

The Tennessee State Law requires physician/dentist/APRN/PA's written order and the parent/guardian's authorization for authorized school staff to administer medications. Medication must be in original pharmacy-prepared container. MEDICATION IN PLASTIC BAGS WILL NOT BE ACCEPTED***. Ask your pharmacist to prepare two labeled containers, one for school and one for home.***

Medication: _____Dosage (amount): _____Time: _____

To be given from/to (dates): _____

Relevant side effects to be observed, if any: _____

If any, plan for management: _____

Physician Signature (required by law): _____Date:_____

*THE VERY FIRST DOSE OF MEDICATION **MAY NOT** BE GIVEN AT SCHOOL / AND PLEASE DO NOT GIVE THE FIRST DOSE AT HOME AND THEN SEND THEM TO SCHOOL. WE NEED FOR YOU TO HAVE TIME TO OBSERVE FOR ANY TYPE OF REACTIONS.

Over the Counter Medication

(To be completed & signed by Parent or Guardian)

Medication: _____ Dosage (amount): _____Time: _____

To be given from/to (dates): _____

Relevant side effects to be observed, if any: _____

If any, plan for management: _____

Medication must be in original container.

Parent or Guardian Authorization:
I request the above medication(s) for my child_____, be administered by school personnel. I understand I must supply all medication to the school in the original container, properly labeled, and will provide no more than a 45 school day supply. Only medications that are medically necessary during school hours for a student's attendance should be sent to school**. All medications will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.**

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____Date: _____

MJCA
Mt. Juliet Christian Academy

Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Attach child's photo

Child's name: _____ **Date of plan:** _____

Date of birth: ____/____/_____ **Age** _____ **Weight:** _____kg

Child has allergy to _____

Child has asthma. ☐ Yes ☐ No (If yes, higher chance severe reaction)
Child has had anaphylaxis. ☐ Yes ☐ No
Child may carry medicine. ☐ Yes ☐ No
Child may give him/herself medicine. ☐ Yes ☐ No (If child refuses/is unable to self-treat, an adult must give medicine)

IMPORTANT REMINDER
Anaphylaxis is a potentially life-threating, severe allergic reaction. If in doubt, give epinephrine.

For Severe Allergy and Anaphylaxis
What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine.**

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

☐ **SPECIAL SITUATION:** If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s):_____. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine.**

Give epinephrine!
What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
   - Ask for ambulance with epinephrine.
   - Tell rescue squad when epinephrine was given.
3. Stay with child and:
   - Call parents and child's doctor.
   - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
   - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
   - Antihistamine
   - Inhaler/bronchodilator

For Mild Allergic Reaction
What to look for

If child has had any mild symptoms, **monitor child.**
Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort

Monitor child
What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

Medicines/Doses

Epinephrine, intramuscular (list type):_____ Dose: ☐ 0.15 mg ☐ 0.30 mg (weight more than 25 kg)
Antihistamine, by mouth (type and dose): _____
Other (for example, inhaler/bronchodilator if child has asthma): _____

_____ _____ _____ _____
Parent/Guardian Authorization Signature **Date** **Physician/HCP Authorization Signature** **Date**

 Your child's doctor will tell you to do what's best for your child. This information should not take the place of talking with your child's doctor.

Self-Carry Medication Authorization

for INHALERS, EPI-PENS and GLUCAGON only

MJCA policy permits a responsible, trained student to carry and/or self-administer medication for asthma, severe allergic reaction, or diabetes on his/her person for immediate use in a life-threatening situation with written order of physician, parent request, school nurse and principal approval.

Student Name/Grade: _____

Condition for which the medication is administered: _____

Name of medication, dose and method administered:_____

Time or indication for administration: _____

Is this a controlled drug? _____ Yes _____ No

Side effects to be noted/reported: _____

Other recommendations:_____

Duration (dates) of administration: From _____ to _____ (limit of one school year)

I request that my child, named above, be permitted to: _____ initial **carry** _____ initial **self-administer** the above ordered medication. I take responsibility for this permission. I understand that the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date or original prescription; strength and dose of medication; and directions for use. No more than a 45 school day supply of medication will be kept at school. ***This medication will be destroyed unless picked up within one week after the end of the school year or end of the medical order.***

Parent Signature: _____ Date: _____

Student Signature: _____Date: _____

Staff only:

We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

Clinic staff signature: _____

Principal signature: _____