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: __________

Hemophilia Management Plan

Student Name: ____DOB________________

Teacher/Grade: ____

Medications to be given at School (name/dose/route):

____

Dates to be given_______________________ Relevant side effects:_________________________________

Medications taken at Home:

____

Usual signs & symptoms child may demonstrate:

____

____

Physical Limitations while at school: ____

Management of all bleeding episodes as follows:

- Apply gloves, cover ice pack and apply to the affected area
- If the arm is affected, elevate it above the heart
- Apply pressure to the affected area for 15minutes
- Notify parent of all bleeding episodes
- Call 911 if student becomes unconscious or symptoms increase in severity
- Other:

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Parent/Guardian signature: ____Date__________

Physician Signature: ____ Date__________