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: _____