Individualized Healthcare Plan

Identifying Information

Student Name & Date of Birth: ____

Teacher/Grade: ____

Home Address: ____

Mother's Name: ____ Lives with? Yes No

Daytime#: _________________ Cell# __________________ Email address: ____________________

Father's Name: ____ Lives with? Yes No

Daytime#: _________________ Cell# __________________ Email address: ____________________

Physician

Physician: ____ Office #: _______________________

Physician Address: ____ Fax#: _____________________

Hospital of Choice: ____

***Emergency Contact** (in addition to or different from above)*

Name: ____ Relationship: ____________________

Daytime #: _______________________ Cell #: __________________________

Name: ____ Relationship: ____________________

Daytime #: _______________________ Cell #: __________________________

Medical Overview

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/Date of Birth/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 or Guardian Printed Name: ____

Signature: ____ Date: ______________________

Asthma Action Plan

Student Name & Date of Birth: ____

Teacher/Grade: ____

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

____

Medications taken at Home:

____

Triggers: (circle all that apply)

Colds Smoke Weather Exercise Dust Air pollution

Animals Food Respiratory infection Temperature Changes Other:

Allergic Reaction to: ____

***We have a nebulizer here at school should you need us to give treatments. BUT YOU HAVE TO PROVIDE THE TUBING, MASK, & MEDICATION.

Usual procedure followed at school for student having asthma attack:

1. Allow student to independently use prescribed asthma medication as needed (identified school staff will provide assistance on an as needed basis)

2. Encourage student to remain calm and take slow, deep breaths

3. Stay with student and monitor response to medication

a. If symptoms decrease within 15 minutes and student is relieved, he/she may return to class

b. If symptoms persist after 15 minutes, contact parent. Allow student to repeat inhaler dosage one time per MD order. Wait another15 min after repeating the inhaler, and if student is relieved, he/she may return to class. If symptoms persist or worsen, follow Emergency Action Plan below

Emergency Action Plan:

1. If symptoms increase in severity (inability to walk or talk, hunched over, chest/neck retraction, can't play, lips gray, air hunger, persistent coughing, etc) call 911.

2. Continue to monitor student's breathing and general conditions.

3. Contact parent and be prepared to take next appropriate action> rescue breathing or CPR until help arrives.

Emergency contacts (if someone other than listed on front page):

Parent/Guardian initials: _________ Physician initials: __________

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/Date of Birth/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)

IN MY OPINION, THIS STUDENT SHOWS CAPABILITY TO CARRY AND SELF-ADMINISTER THE ABOVE MEDICATION.

I request that my child, named above, be permitted to: ______ carry ______ 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: ________________________

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: ____

Parent/Guardian initials: _________