



**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: \_\_\_\_\_



**Cardiac Medical Management Plan**

Student Name & Date of Birth: \_\_\_\_\_

Teacher/Grade: \_\_\_\_\_

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

\_\_\_\_\_

Medications taken at Home:

\_\_\_\_\_

Cardiac Condition: \_\_\_\_\_

Usual signs & symptoms child may demonstrate: \_\_\_\_\_

Normal BP parameters for student: \_\_\_\_\_

Physical Limitations while at school: \_\_\_\_\_

If student complains of chest pain, shortness of breath, and/or has vital signs outside acceptable parameters, school personnel should immediately (circle all that apply):

Call 911 contact Parent/Guardian

Other:

\_\_\_\_\_

Parent/Guardian initials: \_\_\_\_\_ Physician initials: \_\_\_\_\_