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.

Physician Signature/Date: ____

Parent/Guardian Signature/Date: ____

Parent/Guardian initials: __________ Physician 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: ______________________

Parent/Guardian initials: _________ Physician initials: __________

Seizure Individualized Health Plan/Medication Orders

Student Name & Date of Birth: ____

Teacher/Grade: ____

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

____

Medications taken at Home:

____

Classification of Seizure: _______________________________

Usual signs & symptoms of seizure: ____

Plan of Action When Seizure Occurs:

1. Note time of seizure onset
2. Assist student to floor. Clear nearby area of hazards.
3. Place head on padded surface and loosen restrictive clothing
4. DO NOT RESTRAIN OR PLACE ANYTHING IN MOUTH
5. Turn student onto side to prevent aspiration of oral secretions
6. Note type and progression of seizure; also note student's color, breathing, pulse, and level of consciousness
7. If seizure persists longer than 5 minutes, or a second seizure begins shortly after the first, or student is not breathing, CALL 911. Provide first aid and CPR as needed and notify parent immediately
8. Monitor student until the seizure concludes and student is alert/oriented
9. Provide for personal hygiene and privacy as appropriate. If student is tired after the seizure, allow to rest in a supervised area as needed
10. Notify parent as soon as possible

Other Instructions:

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Parent/Guardian initials: _________ Physician initials: __________