Appendix A

Individualized Health Care Plans-revised 12/2014
Emergency plan
Procedure information sheet
Daily log
Medical order forms
Parent authorization forms
Components of an Individualized Health Care Plan

Who should have an Individualized Health Care Plan (IHCP)?

Students with mild to severe health care needs and require frequent nursing services at school should have an IHCP.

What is the purpose of an IHCP?

The IHCP helps assure consistent, safe health care for the student, protects the school nurse in legal proceedings, and provides documentation regarding the extent of services provided. Each IHCP should be individualized to meet the needs of the student.

What should the IHCP include?

The IHCP should include the following four components:

1. Nursing assessment
2. Nursing diagnoses
3. Nursing interventions
4. Expected outcomes

Each IHCP may include additional components to meet the needs of the student. The IHCP should be revised when the student’s physical condition or care changes. Each IHCP should be consistent with minimum standards of care.

IHCPs also should address:

- Physical education classes, if appropriate
- Special activities (i.e., swimming)
- Field trips
- Classroom parties
- Off-campus work opportunities
- Bus transportation
- Medical equipment, supplies, and services

Who should develop and sign the IHCP?

The following individuals should help develop and then sign the IHCP:

- Parents
- Student
- Medical provider (optional)
- Registered school nurse

Parents or legal guardians must authorize, in writing, care provided for their minor children.
Medical providers (physicians, nurse practitioners, physician assistants) must provide written orders for medical treatments provided at school.

**How often should the IHCP be updated?**

The IHCP should be updated as appropriate and revised at least annually (i.e., at least once each school year) or after significant changes occur in the student’s health status.

**What is the Emergency Care Plan?**

The Emergency Care Plan (ECP) is required when a chronic condition has the potential to result in a medical emergency. The ECP is a component of the IHCP.

**Source:**
Legal *Issues in School Health Services.*
Components of an Individualized Health Care Plan (IHCP)

1. **Assessment**
The assessment provides the background information for the IHCP and includes:
   - Health history
   - Current health status
   - Self-care skills/needs
   - Psychosocial status
   - Health issues related to learning

2. **Nursing Diagnosis**
A nursing diagnosis summarizes the current health status of the student based on the student’s response to the health condition and defines what the school nurse can contribute as an autonomous practitioner.

3. **Goals**
Goals are clear, concise, realistic descriptions of desired outcomes. They may be short-term or long-term but they must be measurable.

4. **Nursing Interventions**
A nursing intervention is any treatment performed to reach a goal or desired outcome.

5. **Student Outcome**
An outcome describes what the student is expected to do. It must be realistic and measurable.

6. **Evaluation**
The evaluation consists of periodically reviewing the student’s goals and outcomes; comparing actual versus predicted outcomes; reviewing the interventions; and, if necessary, modifying the IHCP. Evaluations also should occur when the student’s health status changes significantly or when the medical provider changes the student’s prescribed treatment or medications.
Individualized Health Care Plan (IHCP)

Student:

Name ___________________________ Date of Birth ___________________________

Prepared By:

School Nurse ___________________________ Date ___________________________

Approved By:

Parent(s) ___________________________ Date ___________________________

Parent(s) ___________________________ Date ___________________________

Approved By:

Student ___________________________ Date ___________________________

Approved By:

Medical Provider (optional) ___________________________ Date ___________________________

Next Review & Revision Due: ___________________________
Individualized Health Care Plan

Demographics

Student Name ______________________________  Birth Date ______________

Home Address ______________________________

Parent/Guardian ____________________________  Phone _________________

Parent/Guardian ____________________________  Phone _________________

Caregiver __________________________________  Phone _________________

Language spoken at home ______________________

Emergency Contact:

Name ____________________________________  Relationship __________  Phone __________________

Medical Care

Primary Physician ___________________________  Phone _________________

Specialty Physician _________________________  Phone _________________

Health History

Brief health history ________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Special health care needs ________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Other considerations ________________________________

________________________________________________________________________

________________________________________________________________________
Student's Ability to Participate in Care

Allergies
Medication & Dietary Needs

Current Medications (dose, route, time)

__________________________________________________________________________
__________________________________________________________________________
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Special Dietary Requirements

__________________________________________________________________________
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Allergies

__________________________________________________________________________
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## Individualized Health Care Plan - Components

<table>
<thead>
<tr>
<th>Assessment Data</th>
<th>Nursing Diagnosis</th>
<th>Goals</th>
<th>Nursing Interventions</th>
<th>Expected Outcomes</th>
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Procedures

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<th>Procedure</th>
<th>Frequency</th>
<th>Times</th>
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Position of student during procedure

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<th>Ability of student to assist/perform procedure</th>
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Location for procedure

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Equipment needed

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Procedural considerations & precautions

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Staff qualified to assist with procedure

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# Daily Log

**Student Name** ________________  **Class/Grade** ________________

**Procedure**
__________________________________________________________________________

**Parent** ________________  **Phone** ________________

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<tr>
<th>Date/Time</th>
<th>Procedure notes</th>
<th>Observations</th>
<th>Time for Prep, Proc, Doc</th>
<th>Completed by</th>
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# Emergency Plan

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In an emergency occurs:

1. Stay with child
2. Call or have someone else call the school nurse
3. If the school nurse is not available, the following staff members are trained to initiate the emergency plan.

__________________________
__________________________
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__________________________
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# Transportation Plan for Student with Special Health Care Needs

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<th>Class/Grade</th>
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<th>Parent</th>
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<th>Period From</th>
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<th>Review Date</th>
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## 1. Adaptations/Accommodations Required

- [ ] Transportation Aide
- [ ] Bus lift
- [ ] Seat belt
- [ ] Special restraint
- [ ] Wheelchair tie down

Space for equipment: specify ______________________________________________________

## 2. Positioning or Handling Requirements

- [ ] None
- [ ] Describe ________________________________________________________________

## 3. Behavior Considerations

- [ ] None
- [ ] Describe ________________________________________________________________
4. Transportation Staff Training
Training has been provided to drivers and substitute driver(s). _____ yes  _____ no

Describe training provided _______________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Date training completed ________________

5. Student Specific Emergency Procedures

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Medical Orders for Specialized Health Care Procedures

Student Name ____________________________ Birth Date __________________

Home Address _______________________________________________________

Name/description of specialized health care procedure ______________________
_____________________________________________________________________
_____________________________________________________________________

Time or indication for procedure _________________________________________
_____________________________________________________________________
_____________________________________________________________________

Precautions, potential complications & needed actions ______________________
_____________________________________________________________________
_____________________________________________________________________

Person(s) authorized to perform procedure

___ School Nurse ___ Trained School Staff ___ Student

Procedure is to be continued as above until (maximum of one school year)
_____________________________________________________________________

Medical Provider Signature ____________________________ Date _____________

I request that the procedure/treatment be performed to my child, named above. The medical provider explained to me the procedure, its purpose and possible complications.

Parent/Guardian Signature______________________________ Date _____________

Parent/Guardian ______________________________________ Date _____________
Medical Order Form

Student Name _______________________________  Birth Date ____________________

Home Address ________________________________________________________________

Licensed Medical Provider ___________________________  Title ____________________

Phone _____________________________

Date of Order _________________________  Discontinuation Date ________________

Medication ________________________________________________________________

Route of administration _______________________________________________________

Dosage ________________________________________________________________

Frequency ________________________________________________________________

Time(s) of administration ____________________________________________________

Specific directions for administration __________________________________________

__________________________________________________________

Special side effects, contraindications, or possible adverse reactions

__________________________________________________________

Consent for self-administration by student (with approval of parent/guardian & school
nurse) _____Yes _______No

__________________________________________________________

Signature of Medical Provider ___________________________  Date __________________

I request that the medication, names above, be given to my child. The medical provider explained to
me the medication, its purpose and possible complications.

Parent/Guardian Signature ___________________________  Date __________________

Parent/Guardian ___________________________  Date __________________