

# 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.*

National Association of School Nurses. (1998, Revised 2003). *Position Statement: Individualized Health Care Plans.*

## 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 \_\_\_\_\_

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

Assessment Data	Nursing Diagnosis	Goals	Nursing Interventions	Expected Outcomes

# Procedures

Procedure \_\_\_\_\_

Frequency \_\_\_\_\_ Times \_\_\_\_\_

Position of student during procedure \_\_\_\_\_

Ability of student to assist/perform procedure \_\_\_\_\_

Location for procedure \_\_\_\_\_

Equipment needed \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Procedural considerations & precautions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Staff qualified to assist with procedure \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Daily Log

Student Name \_\_\_\_\_

Class/Grade \_\_\_\_\_

Procedure \_\_\_\_\_

Parent \_\_\_\_\_

Phone \_\_\_\_\_

Date/Time	Procedure notes	Observations	Time for Prep, Proc, Doc	Completed by

# Emergency Plan

Student Name \_\_\_\_\_

Class/Grade \_\_\_\_\_

Parent \_\_\_\_\_

Phone \_\_\_\_\_

If you see this	Do this

**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.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Transportation Plan for Student with  
Special Health Care Needs**

**Student Name** \_\_\_\_\_

**Class/Grade** \_\_\_\_\_

**Parent** \_\_\_\_\_

**Phone** \_\_\_\_\_

**Period From** \_\_\_\_\_

**To** \_\_\_\_\_

**Review Date** \_\_\_\_\_

**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 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## 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 \_\_\_\_\_