Individualized Healthcare Plan

Use this customizable template to update your child's information at the beginning of every school year. Parents may request that this document be placed in the school nurse's office or in the child's permanent record. You can also give a copy to your child's classroom teacher.
Note: Your school district may have a template you should use.

STUDENT INFORMATION

Name:		Date of Birth:
Address:	City, State, Zip:	
School:	Grade:	Primary Language:

PARENT/GUARDIAN INFORMATION

Child resides with: Mother ☐ Father ☐ Both ☐

Parent Name:			
Address: (if different then student)		City, State, Zip:	
Phone:	Home:	Work:	Cell:
Primary Language:			

OTHER EMERGENCY CONTACT INFORMATION

Name:	Name:
Relationship to Student:	Relationship to Student:
Phone:	Phone:

HEALTHCARE PROVIDER INFORMATION

Primary Care Physician	Specialty Care Provider
Name:	Name:
Date of Last Exam:	Date of Last Exam:
Phone:	Phone:
Specialty Care Provider	**Specialty Care Provider**
Name:	Name:
Date of Last Exam:	Date of Last Exam:
Phone:	Phone:

IHP Supplements (attached):
☐ Crisis Plan (recommended) ☐ Medication (recommended)
☐ Hospitalization & Insurance ☐ Field Trip & School Sponsored Activities

STUDENT'S HEALTHCARE INFORMATION

Primary Diagnosis:
Other Diagnoses:
Allergies: list both food and medication allergies

POTENTIAL PROBLEMS

Triggers	What to look for

TREATMENT PLAN

List possible interventions or treatments that may take place during the school day.

Interventions	Treatments
Person Responsible for Implementation and Documentation:	

TEAM REVIEW

Each team member should initial and date after review of the completed plan.

☐ School Nurse ☐ Parent/Guardian ☐ Other (specify) ☐ Student

☐ Healthcare Provider: Name: _____ Phone: _____

CRISIS PLAN
IHP Supplement

Student Name: _____

It is recommended that this document be attached to the student's Individualized Healthcare Plan (IHP). This form should be shared with all individuals who work with the student, including teachers, coaches, bus drivers and support staff. This crisis plan should be developed by the parents/guardian, school nurse, student, and other pertinent school officials. This plan needs to be reviewed and revised every year or more frequently as health issues change. This plan can also be attached to the student's IEP or 504 Plan, if applicable.

CRISIS SITUATIONS

If this occurs: *Define specific behaviors/conditions*	**Do this:** *Define intervention steps*

EMERGENCY SITUATIONS

1. Call 911
2. Designate an adult to stay with the student. Clear areas of any potential risk factors to the student.
3. Call the school nurse, principal or other designated personnel to assist.
4. If the event occurs in an area where other students are present, have a designated adult lead them to another room.
5. Contact their parent/guardian.

Other steps: *List any other emergency steps to follow based on student's special health care needs.*

FIELD TRIP & SCHOOL SPONSORED ACTIVITIES
IHP Supplement

If a field trip is planned, the teacher should give two weeks' notice to the school nurse so that a plan can be put into place for the student. The plan should always include medication and emergency supplies. In some cases, a nurse or parent may be needed to accompany a student.

Please feel free to update this form for each field trip and bring a copy to your student's nurse to have in her/his/their file.

☐ Field Trip ☐ PE or Physical Activity		
Name of Student:		Date of Birth:
School:	Grade:	Date of Field Trip:

HEALTHCARE PROVIDER INFORMATION

Primary Care Physician	Specialty Care Provider
Name:	Name:
Phone:	Phone:
Physician or HTC near location (for field trips that are not near home)	
HTC or Hospital:	Address:
Phone:	City, State, Zip:

MEDICATION NEEDED FOR FIELD TRIP/PHYSICAL ACTIVITY		
Medication Name:		Administered during field trip day? Yes ☐ No ☐
Reason for taking:		Possible Side Effects:
Dosage:	Frequency:	Method of Admin:
Medication Name:		Administered during field trip day? Yes ☐ No ☐
Reason for taking:		Possible Side Effects:
Dosage:	Frequency:	Method of Admin:

ACCOMODATIONS NEEDED FOR FIELD TRIP/PHYSICAL ACTIVITY *
1.
2.
3.
4.
5.

* Wheelchair, ice packs, student limitations, etc.

MEDICATION LIST
IHP Supplement

Student Name: _____

It is recommended that this document be attached to the student's Individualized Healthcare Plan (IHP). This medication list should be developed by the parents/guardian, school nurse, student, and other pertinent school officials. This plan needs to be reviewed and revised yearly or more frequently as health issues change. This plan can also be attached to the student's IEP or 504 Plan, if applicable.

CURRENT MEDICATIONS

Medication Name:		Administered during school day? Yes☐No☐	
Reason for taking:		Possible Side Effects:	
Dosage:	Frequency:	Method of Admin:	Date Started:
Medication Name:		Administered during school day? Yes☐No☐	
Reason for taking:		Possible Side Effects:	
Dosage:	Frequency:	Dosage:	Frequency:
Medication Name:		Administered during school day? Yes☐No☐	
Reason for taking:		Possible Side Effects:	
Dosage:	Frequency:	Dosage:	Frequency:
Medication Name:		Administered during school day? Yes☐No☐	
Reason for taking:		Possible Side Effects:	
Dosage:	Frequency:	Dosage:	Frequency:
Medication Name:		Administered during school day? Yes☐No☐	
Reason for taking:		Possible Side Effects:	
Dosage:	Frequency:	Dosage:	Frequency:

MEDICATION ALLERGIES OR AVERSIONS

Medication	Reaction	What to do in case of accidental administration

HOSPITAL ADMISSIONS & INSURANCE INFORMATION

IHP Supplement

Student Name: _____

This document should be attached to the Individualized Healthcare Plan (IHP). This form should be developed by the parents/guardian, school nurse, student, and other pertinent school officials. This plan needs to be reviewed and revised yearly or more frequently as health issues change. This plan can also be attached to the student's IEP or 504 Plan, if applicable. (Please print a second sheet if needed)

HOSPITAL ADMISSIONS (Within the past 12 months)

Date:	Reason:	Date:	Reason:
Outcome:		Outcome:	
Date:	Reason:	Date:	Reason:
Outcome:		Outcome:	
Date:	Reason:	Date:	Reason:
Outcome:		Outcome:	
Date:	Reason:	Date:	Reason:
Outcome:		Outcome:	
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Outcome:		Outcome:	
Date:	Reason:	Date:	Reason:
Outcome:		Outcome:	
Date:	Reason:	Date:	Reason:
Outcome:		Outcome:	

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance
Policy Holder:	Policy Holder:
Company:	Company: