Individualized Health Care Plan

Name: _____ Date: _____

Health Care Plan

Written and submitted by: _____ (school nurse) (date)

Reviewed and signed by:

Parent/Guardian and Student _____ (name) (date)

_____ (name) (date)

Education Administrator: _____ (name) (date)

Reviewed and/or signed by physician: _____ (name) (date)

Next review and revision of health care plan: _____ (date)

Health care plan should be revised according to student's specific needs.

Individualized Health Care Plan Checklist

Preparation for Entry:

☐ Home Visit/Assessment _____ (date)

☐ Health History _____ (date)

☐ Planning Meetings _____ (date) _____ (date) _____ (date)

☐ Staff Training Meetings _____ (date) _____ (date) _____ (date)

☐ Educational Team Meetings _____ (date) _____ (date) _____ (date)

Health Care Plan Included in:

☐ Student Record _____ (date)

☐ Individualized Education Program _____ (date)

☐ Individualized Student Accommodation Plan _____ (date)

Health Care Plan

☐ Health Assessment _____ (date)

☐ Physician's Order for Medications _____ (date)

☐ Health Care Procedure _____ (date)

☐ Student-Specific Procedural Guidelines _____ (date)

☐ Procedural Skills Checklist _____ (date)

☐ Problems/Goals/Actions _____ (date)

Emergency Plan

☐ School _____ (date)

☐ In Transit _____ (date)

☐ Health Care Plan Reviewed by Physician _____ (date)

☐ Signed by Parent, Education Administrator, School Nurse/Health Care Coordinator _____ (date)

_____
(School Nurse/Health Care Coordinator)

_____
(Education Coordinator)

Individualized Health Care Plan

Student Information:

_____ (Name) _____ (Birthdate)

_____ (Parent/Guardian) _____ (Address)

Mother/Guardian: _____ (Home telephone) _____ (Work telephone)

Father/Guardian: _____ (Home telephone) _____ (Work telephone)

_____ (School) _____ (Grade/Class)

Language(s) spoken; student: _____ Caregiver(s): _____

Immunizations: (date and type) _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Primary Physician: _____ Telephone: _____

Specialty Physicians:

_____ Telephone: _____

_____ Telephone: _____

_____ Telephone: _____

_____ Telephone: _____

_____ Telephone: _____

In Emergency, Notify:

Name: _____ Telephone: _____ Relationship: _____

Name: _____ Telephone: _____ Relationship: _____

Name: _____ Date: _____

Important Personnel

School contacts:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Direct caregivers:	Training: Student-specific	Training: General
_____	_____ (date)	_____ (date)
_____	_____ (date)	_____ (date)

Substitute caregivers/back-up staff:

_____	_____ (date)	_____ (date)
_____	_____ (date)	_____ (date)
_____	_____ (date)	_____ (date)
_____	_____ (date)	_____ (date)

Student-specific training done by:

_____ _____ (date)

General staff training done by:

_____ _____ (date)

Peer awareness training done by:

_____ _____ (date)

Name: _____ Date: _____

Background Information

Brief health history: _____

Special health care needs of the student: _____

Other considerations: _____

Student participation in care: _____

Baseline status (i.e., skin color, activity/energy level, blood pressure, pulse, temperature, respirations): _____

Medication (dose, route, time): _____

Diet: _____

Allergies: _____

Transportation needs: _____

What is the transportation emergency communication system: _____

Name: _____ Date: _____

Procedure Information Sheet

Procedure: _____

Frequency: _____ Times: _____

Position of student during procedure: _____

Ability of the student to assist/perform procedure: _____

_____

Suggested setting for procedure: _____

Equipment (include make and model when applicable):

Daily: _____

_____

_____

_____

_____

_____

Emergency: _____

_____

_____

_____

_____

_____

Checked by: _____

Storage: _____

Maintenance: _____

Home care company: _____

Checked by: _____

Storage: _____

Maintenance: _____

Home care company: _____

Child-specific techniques and helpful hints: _____

_____

_____

_____

_____

_____

_____

Procedural considerations and precautions: _____

_____

_____

_____

_____

_____

_____

Name: _____ Date: _____

Possible Problems

Observation	Reason	Action

Name: _____ Date: _____

School Nurse: _____

Individualized Health Care Plan

Date	Health Need/Nursing Diagnosis	Goals	Action/Intervention	Evaluation

Date	Health Need/Nursing Diagnosis	Goals	Action/Intervention	Evaluation

DAILY LOG

Name: ______________________________ School: ____________________

Procedure(s): ____

Parent: ______________________________ Telephone number: ____________

Date/time	Procedure notes	Observations	Name

Emergency Plan

Name: _____ **Date:** _____

Child-specific emergencies:

If you see this	Do this

If an emergency occurs:

1. **Stay with child.**
2. **Call or designate someone to call the nurse.**
   - **State who you are.**
   - **State where you are.**
   - **State the problem.**
3. **The school nurse will assess the child and decide whether the emergency plan should be implemented.**
4. **If the school nurse is unavailable, the following staff members are trained to initiate the emergency plan:**

_____

_____

_____

_____

_____

Emergency Telephone Procedure

Name: _____ Date: _____

1. **Dial 911 and/or designated emergency response team.**
2. **State who you are:** "I am _____, a nurse/teacher/paraprofessional in the _____ school."
3. **State where you are.**
   School name: _____
   Address: _____
   City: _____
4. **State what is wrong with student.**
5. **Give specific directions** (e.g., which school entrance should be used, location of student).
6. **Do not hang up.** Ask for the information to be repeated and provide any other necessary information. Hang up only when all information has been received and is correct.
7. **Notify people.**
   a. School principal or school official in charge of the building at that time: _____ (telephone number)
   b. School back-up personnel: _____ (telephone number)
8. **State the following:**
   "Emergency plan for _____ is in effect."
   "The student is located _____."
9. **Do the following:**
   a. Meet the emergency response team.
   b. Direct emergency response team to the emergency area.
   c. Call parents and other necessary individuals (including physician).

An adult should be designated to accompany student in the ambulance.

Hospital that the student should be transported to: _____.

Emergency Information

Name: _____ Birthdate: _____

Address: _____ Telephone number: _____

Mother/Guardian: _____

Home telephone number: _____ Work telephone number: _____

Father/Guardian: _____

Home telephone number: _____ Work telephone number: _____

Other contact: _____ Telephone number: _____

Health insurance: _____ Telephone number: _____

Emergency numbers:

Emergency medical response team: _____ Telephone number: _____

Fire: _____ Telephone number: _____

Police: _____ Telephone number: _____

Home care company: _____ Telephone number: _____

Ambulance: _____ Telephone number: _____

Gas company: _____ Telephone number: _____

Electric company: _____ Telephone number: _____

Preferred hospital:

_____ Telephone number: _____

Local hospital emergency room:

_____ Telephone number: _____

Primary physician: _____ Telephone number: _____

Dentist: _____ Telephone number: _____

Specialists:

_____ Telephone number: _____

_____ Telephone number: _____

_____ Telephone number: _____

_____ Telephone number: _____

_____ Telephone number: _____

Parent Authorization for Specialized Health Care

We (I), the undersigned, who are the parents/guardians of

_____
(name) (birthdate)

request that the following health care service(s) _____

_____

_____

_____

_____

_____

be administered to our child. We understand that a qualified designated person(s) will be performing the above-mentioned health care service. It is our understanding that in performing this service, the designated person(s) will be using a standardized procedure that has been approved by our physician.

_____
(name) (address) (telephone number)

We will notify the school immediately if the health status of _____ changes, we change physicians, or there is a change or cancellation of the procedure.

We understand that the above procedure should be scheduled before or after school hours whenever possible.

Signature of parents/guardians: _____

_____

Address: _____

Telephone numbers: _____ _____
(home) (work)

_____ _____
(home) (work)

Date: _____

This authorization form is from Pupil Personnel Services. (1983). *Recommended practices and procedures manual.* Chicago: Illinois State Department of Education; adapted by permission.

Physician's Order for Specialized Health Care Procedure

Student's name: _____ Birthdate: _____

Address: _____

☐ I have reviewed and approve the Health Care Plan as written

☐ I have reviewed and approve the Health Care Plan with the indicated changes/suggestions

Physician's Name (Print): _____

Address: _____

Telephone: _____

Signature: _____ Date: _____

Procedures:

Name	Frequency	Indications	Date of Order	Expiration Date

Physician's Order For Medication Administration

Student's name: _____ Birthdate: _____

Address: _____

☐ I have reviewed and approve the Health Care Plan as written

☐ I have reviewed and approve the Health Care Plan with the indicated changes/suggestions

Physician's Name (Print): _____

Address: _____

Telephone: _____

Signature: _____ Date: _____

Medications:

Name	Dose/Frequency	Time	Route	Date of Order	Expiration Date

Sample Single Medication Order Form to Be Completed by a Licensed Prescriber

Student name: _____ Birthdate: _____

Address: _____ Grade: _____
(street) (city/town)

Name of licensed prescriber: _____ Title: _____

Business telephone number: _____

Emergency telephone number: _____

Medication: _____

Route of administration: _____ Dosage: _____

Frequency: _____ Time(s) of administration: _____

(Please note: *Whenever possible, medication should be scheduled at times other than school hours.*)

Specific directions or information for administration: _____

Date of order: _____ Discontinuation date: _____

Diagnosis[1]: _____

Any other medical condition(s)[1]: _____

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed: _____

   _____

   _____

2. Other medication being taken by the student: _____

   _____

   _____

3. The date of the next scheduled visit or when advised to return to prescriber: _____

   _____

4. Consent for self-administration (provided the school nurse determines it is safe and appropriate):

   Yes _____ No _____

_____
Signature of licensed prescriber

Date: _____

[1]if not in violation of confidentiality.

From Goodman, I.F., & Sheetz, A.H. (Eds.). (1995). *The comprehensive school health manual.* Boston: School Health Unit, Bureau of Family and Community Health, Massachusetts Department of Public Health; reprinted by permission.

Checklist of Items for Consideration in Developing Individualized Education Plans (IEP) for Students with Physical Disabilities or Special Health Needs

The following checklist contains items often identified by parents and professionals as important components of appropriate educational plans. Not all items will be important to all students; some students may have needs that are not reflected here. We invite your comments and suggestions for additions that can be included in future revisions.

TRANSPORTATION

- ☐ Regular bus
- ☐ Van
- ☐ Wheelchair car
- ☐ Special equipment
- ☐ Seat belt
- ☐ Car seat
- ☐ Other _____

- ☐ Special Assistance
  - ☐ To and from home to vehicle
  - ☐ To and from school to vehicle
  - ☐ Aide
  - ☐ Positioning
  - ☐ Other _____

NOTES: _____

_____

ACCESSIBILITY

- ☐ Use of elevators
- ☐ Bathrooms
- ☐ Classrooms
- ☐ Gym
- ☐ Cafeteria
- ☐ Library
- ☐ Vocational areas
- ☐ Auditorium (stage)
- ☐ Administrative offices
- ☐ Locker location
- ☐ Other _____

NOTES: _____

_____

THERAPIES

- ☐ Occupational therapy
- ☐ Physical therapy
- ☐ Speech therapy
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

NOTES: _____

_____

SELF-HELP SKILLS

- ☐ Eating
- ☐ Dressing
- ☐ Toileting
- ☐ Student needs:
  - ☐ Assistance
  - ☐ Training
- ☐ Grooming
  - ☐ Bathing/washing
  - ☐ Tooth brushing
  - ☐ Other _____

NOTES: _____

_____

From Anderson, B. (1980). *Checklist of items for consideration in developing individualized education plans (IEP) for students with physical disabilities or special health needs.* Boston: Federation for Children with Special Needs, Collaboration Among Parents and Health Professionals (CAPP) Project; reprinted by permission.

CURRICULUM

- ☐ Materials to be modified
  - ☐ Taped
  - ☐ Written in large print
  - ☐ Computer software
  - ☐ Other _____
- ☐ Timelines set
- ☐ Responsibility assigned
- ☐ Methods to be adapted
  - ☐ Timelines for completing tasks/assignments/tests
  - ☐ Written *and* spoken
  - ☐ Use of computer

NOTES: _____

_____

CLASSWORK

- ☐ Backup tutoring
  - ☐ Regularly scheduled
  - ☐ As needed
- ☐ Make-up assistance
  - ☐ Regularly scheduled
  - ☐ As needed

NOTES: _____

_____

PHYSICAL EDUCATION

- ☐ Regular program
- ☐ Modified regular program
- ☐ Adaptive physical education program
- ☐ Other _____
- ☐ Special equipment
- ☐ Special staff
- ☐ Other _____
- ☐ Other _____

NOTES: _____

_____

ENRICHMENT CLASSES/ACTIVITIES

- ☐ Art
- ☐ Music
- ☐ Computer
- ☐ Other _____
- ☐ Modifications needed
  - ☐ Special equipment
  - ☐ Special staff
  - ☐ Other _____

NOTES: _____

_____

EQUIPMENT NEEDED

- ☐ Typewriter
- ☐ Computer
- ☐ Special grip pencils
- ☐ Communication devices
- ☐ Extra set of books for home
- ☐ Other _____

NOTES: _____

_____

MEDICATIONS

- ☐ Who administers:
  - ☐ Student
  - ☐ Nurse
  - ☐ Teacher
  - ☐ Backup person
- ☐ Side effects implications for
  - ☐ Regular school schedule
  - ☐ Test schedule
  - ☐ Special events/activities
- ☐ Storage
- ☐ Recordkeeping, logs
- ☐ Instructions on self-administering for student

NOTES: _____

_____

SPECIAL HEALTH NEEDS AT SCHOOL

- ☐ Regular basis
- ☐ As needed
- ☐ Use of bathroom as needed
- ☐ Other _____

- ☐ Specify
  - ☐ Who
  - ☐ What
  - ☐ Backup person

NOTES: _____

_____

SPECIAL SUPPLIES OR EQUIPMENT

- ☐ Storage
- ☐ Whose responsibility

- ☐ At school only
- ☐ Shared between home and school

Other considerations: _____

NOTES: _____

_____

BACKUP MEDICAL SUPPORT:

List specific health-related emergencies that may occur: _____

_____

_____

_____

Who to contact _____

Where to go _____

What to do in an emergency _____

_____

_____

NOTES: _____

_____

MOBILITY

- ☐ Need for assistance
- ☐ Regular method/person
- ☐ Backup person
- ☐ Use of elevator
- ☐ Other _____

- ☐ Proximity considerations for developing schedule
- ☐ Classrooms
- ☐ Lunchroom
- ☐ Gym
- ☐ Other _____

NOTES: _____

_____

POSITIONING

- ☐ Wheelchair
- ☐ Car
- ☐ Classroom
- ☐ Gym
- ☐ Lunch
- ☐ Other _____

- ☐ Aids
  - ☐ Prone board
  - ☐ Back supports
  - ☐ Other _____
  - ☐ When _____

NOTES: _____

_____

STAMINA

- ☐ Scheduling concerns
- ☐ Length of day
- ☐ Effect on testing, especially timed ones
- ☐ Breaks/rest periods
  - ☐ As needed
  - ☐ Regularly scheduled

- ☐ Identifiable signs of fatigue
- ☐ Whose responsibility
- ☐ Whose authority
- ☐ Role of student

NOTES: _____

_____

FIRE SAFETY

- ☐ Plan
- ☐ Who is responsible
- ☐ Backup person

NOTES: _____

_____

FIELD TRIPS

- ☐ Early notification
- ☐ Transportation
- ☐ Aide
- ☐ Other _____

NOTES: _____

_____

EXTRACURRICULAR ACTIVITIES/PROGRAMS (This is a Section 504 issue)

- ☐ Special learning opportunities
  - ☐ Drivers education
  - ☐ Work experience
  - ☐ Job placement programs
  - ☐ Other _____
- ☐ Extended day programs
- ☐ Clubs
- ☐ Sports programs
- ☐ Social events
- ☐ Transportation
- ☐ Aide
- ☐ Accessibility

NOTES: _____

_____

HOME/HOSPITAL TUTORING

- ☐ Needed now
- ☐ Possibly needed later
- ☐ Outline plan (even if tentative)

NOTES: _____

_____

General Classroom Inclusion Checklist

Directions: Record a "y" for yes and an "n" for no on the blank preceding each item. If the answer to any of the items is "no" your team may wish to consider whether any changes should be made and what those changes might be.

Going with the Flow:

____ Does the student enter the classroom at the same time as classmates? _____

____ Is the student positioned so that she or he can see and participate in what is going on? _____

____ Is the student positioned so that classmates and teachers may interact easily with him or her (e.g., without teacher between the student and his or her classmates, not isolated from classmates)? _____

____ Does the student engage in classroom activities at the same time as classmates? _____

____ Does the student make transitions in the classroom at the same time as classmates? _____

____ Is the student involved in the same activities as his or her classmates? _____

____ Does the student exit the classroom at the same time as classmates? _____

Acting Cool:

____ Is the student actively involved in class activities (e.g., asks or responds to questions, plays a role in group activities)? _____

____ Is the student encouraged to follow the same classroom and social rules as classmates (e.g., hugs others only when appropriate, stays in seat during instruction)? _____

____ Is the student given assistance only as necessary (assistance should be phased out as soon as possible)? _____

____ Is assistance provided for the student by classmates (e.g., transitions to other classrooms, within the classroom)? _____

____ Are classmates encouraged to provide assistance to the student? _____

____ Are classmates encouraged to ask for assistance from the student? _____

____ Is assistance provided for the student by classroom teachers? _____

____ Does the student use the same or similar materials during classroom activities as his or her classmates (e.g., popular actors on notebooks, school mascot on folders)? _____

Talking Straight:

____ Does the student have a way to communicate with classmates? _____

____ Do classmates know how to communicate with the student? _____

____ Does the student greet others in a manner similar to that of his or her classmates? _____

____ Does the student socialize with classmates? _____

____ Is this facilitated? _____

____ Does the student interact with teachers? _____

____ Is this facilitated? _____

____ Do teachers (e.g., classroom teachers, special education support staff) provide the same type of feedback (e.g., praise, discipline) for the student as for his or her classmates? _____

____ If the student uses an alternative communication system, do classmates know how to use it? _____

____ If the student uses an alternative communication system, do teachers know how to use it? _____

____ Is the system always available to the student? _____

Looking Good:

____ Is the student given the opportunity to attend to his or her appearance as classmates do (e.g., check appearance in mirror between classes)? _____

____ Does the student have accessories that are similar to his or her classmates (e.g., backpacks, friendship bracelets, hair jewelry)? _____

____ Is the student dressed similarly to classmates? _____

____ Is clothing needed for activities age appropriate (e.g., napkins instead of bibs, "cool" paint shirts)? _____

____ Are personal supplies or belongings carried or transported discreetly? _____

____ Is the student's equipment (e.g., wheelchair) kept clean? _____

Given the opportunity (and assistance as needed):

____ Is the student's hair combed?

____ Are the student's hands clean and dry?

____ Does the student change clothing to maintain a neat appearance?

____ Does the student use chewing gum, breath mints, breath spray?

From Vandercook, T., & York, J. (1990). A team approach to program development and support. In Stainback, W., & Stainback, S. (Eds.), *Support networks for inclusive schooling: Interdependent integrated education* (pp. 117–118). Baltimore: Paul H. Brookes Publishing Co.; adapted by permission.