School District Logo

SCHOOL YEAR

Confidential Individualized Healthcare Plan

School Nurse Name & Phone Number (school fax)

Student Name: **Birth Date** **School** **Grade** **Student #**

Parent/Guardian:	**Name & Phone #**
Parent/Guardian:	**Name & Phone #**
Healthcare Provider	**Primary Care Provider & Phone #**
Healthcare Provider	**Specialist & Phone #**
Preferred Hospital:	**Preferred Hospital**
Emergency Contact:	**Name, Relationship & Phone #**
CURRENT HEALTH ISSUES	
PERTINENT HEALTH HISTORY	
CURRENT MEDICATIONS:	**AT HOME:** **AT SCHOOL:**
ALLERGIES:	
RESTRICTIONS:	relevant activity/diet
CURRENT MEDICATIONS:	**AT HOME** **AT SCHOOL:**
HEALTH CONCERN(S):	
Concern:	**Goal:** **Action:** ☐
Concern:	**Goal:** **Action:** ☐
Concern:	**Goal:** **Action:** ☐
EMERGENCY ACTION PLAN	Shelter in place Evacuation plan

Personal Care Services/ Medically Necessary Services *(repeat segment if more than one service)*
ICD-10 Code:

Specific task: *example: feeding, cath, diaper change*
Scope: *What is the related service that is needed for the student?*
Duration: *How long does the service take? (minutes or hours/per instance)*
Frequency: *How many times does it need to be done per day? (number times per day or as needed)*

This service is medically necessary through the following dates, not to exceed one year.
Start Date: **End Date***:*

Student Name:	**Birth Date**	**School**	**Grade**	**Student #**

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and equipment devices. I approve this Individualized Healthcare Plan for my child.

parent/guardian date

school nurse date

health care provider

date

administrator

date

student (optional)

date