

IHCP Medical Information Form

Clinician: _____ Contact person: _____ Facility: _____ Phone: _____ Emergency Phone: _____	Student name: _____ School: _____ Date: _____ Previous Update: _____ <i>(shall be updated at least annually)</i>
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The purpose of this form is to provide accurate information to the school about an individual student's medical needs. It is a prerequisite for any accommodations. For ongoing communication to occur, both the parent(s)/guardian(s) and the health care provider must sign the release of medical information authorization on the back of the form, as per the federal regulations concerning sharing of educational and health information.

Conditions: _____ _____ _____ _____ _____ _____ Allergies: _____ _____ _____	Treatment Plan: _____ _____ _____ _____ _____ _____ _____ _____ _____
Equipment: _____ _____ _____ Procedures: _____ _____ _____ _____ <input type="checkbox"/> No Equipment <input type="checkbox"/> No Procedures	Activity Level: <input type="checkbox"/> No Restrictions Restrictions: (check all that apply) <input type="checkbox"/> No contact sports <input type="checkbox"/> No exertion other than walking <input type="checkbox"/> No exposure to cold air (such as at recess, bus stop, physical education) <input type="checkbox"/> No stairs <input type="checkbox"/> Other (specify): _____ _____ _____
In School Medications: <input type="checkbox"/> YES – Authorization attached * <input type="checkbox"/> NO – Medications not given in school * State regulations require parent/ guardian and physician authorization of nurse administration of school medications	Other Medications: <i>(Please list all medications child takes, even if not given during school hours.)</i> _____ _____ _____ _____

Medical Transportation:

- Door to door (child has no exercise tolerance) duration: _____
- Corner to corner (limited exercise tolerance) duration: _____
- Special vehicle (wheelchair)
- PFT's if asthmatic: please attach last pulmonary function testing _____

Medical transportation is provided for medical reasons only. Safety issues (i.e., bullies, bus stop location, walking distance, parental/guardian illness) require other solutions. Please discuss this with the school nurse.

Other Adaptations:

Tutoring Plan: (anticipated total absence of > 2 weeks/yr. for chronic illnesses such as sickle cell, cystic fibrosis, etc.)

Special Diet: _____

Access accommodations: (e.g., bathroom, elevator, etc.) _____

Primary Care Provider Signature: _____

Authorization for Healthcare Provider and School Nurse to Share Information:

I authorize my child's school nurse to assess my child as regards his/her special health care needs and to discuss these needs with my child's primary care provider, as needed through the school year. I understand this is for the purpose of generating a health care plan for my child. I understand I may withdraw this authorization at any time and that this authorization must be renewed annually.

Parent/Guardian Signature

Print Name

Date

School Use Only

<input type="checkbox"/> USS team involved date presented: _____ <input type="checkbox"/> Action taken: _____ _____ _____ _____ _____ _____	ATTACHMENTS: <input type="checkbox"/> Emergency Plan <input type="checkbox"/> Medication Plan <input type="checkbox"/> IEP Health Accommodations <input type="checkbox"/> Field Trip Plan
<input type="checkbox"/> Transportation provided <input type="checkbox"/> Other accommodations provided <input type="checkbox"/> Personnel trained (if applicable) <input type="checkbox"/> Parent/Guardian authorization Feedback to clinician given	Child also has: <input type="checkbox"/> IEP <input type="checkbox"/> 504 Plan <input type="checkbox"/> Individual Psychosocial plan

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)

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Name: _____

Date: _____

Important Personnel

School contacts:

_____	_____
_____	_____
_____	_____
_____	_____

Training
Direct caregivers:

Student-specific

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)

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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? _____

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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: _____

Checked by: _____

Storage: _____

Storage: _____

Maintenance: _____

Maintenance: _____

Home care company _____

Home care company _____

Child-specific techniques and helpful hints: _____

Procedural considerations and precautions: _____

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Exhibit 7-9

Name: _____

Date: _____

School Nurse: _____

Individualized Health Care Plan

Date	Health Need/Nursing Diagnosis	Goals	Action/Intervention	Evaluation

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Exhibit 7-10

Daily Log

Name: _____ School: _____

Procedure(s): _____

Parent/Guardian _____ Telephone Number _____

Date/Time	Procedure notes	Observations	Name

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Exhibit 7-11

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:

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Exhibit 7-12

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: _____

(Name)

(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 the 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: _____.

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Exhibit 7-13

Emergency Information

Name: _____ Birthdate: _____

Address: _____ Telephone number _____

Mother/Guardian: _____

Home telephone number: _____ Work telephone number: _____

Emergency numbers:

Emergency medical response team: _____ Work telephone number: _____

Other contact: _____ Telephone number: _____

Health insurance: _____ 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: _____

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Exhibit 7-14

Parent/Guardian Authorization for Specialized Health Care

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

_____ (Name) _____ (Birthdate)

request the following health care
service/service(s) _____

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

_____ (Physician's 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)

Date: _____

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Exhibit 7-15

Physician's Order for Specialized Health Care Procedure

Student's Name: _____ Birthdate: _____

Physician's Name (Print): _____

Address: _____

Address: _____

Telephone: _____

Signature: _____

Date: _____

- I have and approve the Health Care Plan as written.
- I have reviewed and approve the Health Care Plan with the indicated changes/suggestions.

Procedures:

Name	Frequency	Indications	Date of Order	Expiration Date

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