Confidential Individualized Health Care Plan

Current Health Issues: _____

_____

Student Name: _____ DOB: _____ Grade: _____

Student Picture

Contact Information:

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Preferred Hospital: _____ Relationship: _____

Building Health Office/School Nurse: _____ Phone: _____

Healthcare Providers	Primary/Spec	Phone	Hospital	Additional Information

Pertinent Health Issues

_____

_____

_____

Medications and Restrictions

Current Medications _____ Allergies _____

Restrictions (relevant activity/diet) _____

PLAN (IHP)

Nursing Diagnosis: _____

_____

Goal: _____ Intervention _____

Expected Outcome: _____

Goal: _____ Intervention _____

Expected Outcome: _____

Goal: _____ Intervention _____

Expected Outcome: _____

Personal Care Services/ Medically Necessary Services (Repeat segment if more than one service)

Specific Task (feeding, cath, diapering, etc.) _____

Scope (Where are supplies/procedures, staff trained and delegated, etc.) _____

Duration (How long does the service take? minutes or hours/per instance) _____

Frequency (How many times does it need to be done per day?) _____

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

PLANs for staff (Describe plans developed and where plans can be found EAP, Shelter in Place, Delegation of Care)

_____

_____

Individualized Health care plan written by: _____ Date: _____

Initial Review/Follow up provided by: _____ Date: _____

Second Review/Follow up provided by: _____ Date: _____