

School Year:

Nursing Services Individual HealthCare Plan (IHP)

To be updated annually or sooner as needed

Student Name (last, first):	DOB:	(optional) Gender:	Grade:	School:
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Medicaid ID: Current ICD Code: Health Care Provider:

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Primary

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Insurance: Medical Diagnosis on File:

Initial Assessment Summary:
Allergies:
Medical History:

ND #	Nursing Diagnosis	Goals	Interventions	Person Responsible
1				
2				
3				

Initial Assessment Summary:							Allergies:	
Nursing Diagnosis		Goals		Interventions			Person Responsible	
		1.						
		2.						
		3.						
Expected Student Outcome		Expected Student Outcome		Expected Student Outcome			Expected Student Outcome	
Plan of Care Date	Additional Assessment Information	Goal # Addressed	Medication, Treatment or Procedure	Dose	Frequency	Discontinue	Nurse Signature	

IHP Approvals (if applicable)

This IHP for _____ was prepared by the following nurse:

RN's signature: _____ Date: _____

RN's name (*print/type*): _____ RN's initials: _____

Additional school staff signature (if applicable): _____

Review plan: beginning of next school year upon parent/health care practitioner/school request other: _____

IHP Approvals (if not already obtained through the medical order)

Note: By signing this document, the parent/guardian and/or the student authorize sharing this information with school personnel who have a legitimate need for knowledge of the information.

Parent/guardian:

I agree with this plan of care for my child while he or she is at school or is attending school-sponsored functions. I agree to let the school know of changes in my child's health condition or treatment and changes to the contact information on page 1 of this individual health care plan.

Sign name: _____

Print name: _____

Date: _____

Health care practitioner:

I agree with this plan of care while at school or attending school-sponsored functions.

Sign name: _____

Print name: _____

Date: _____

Student (if appropriate):

I agree with this plan of care for me while I am at school or school-sponsored functions.

Sign name: _____

Print name: _____

Date: _____

Health care practitioner:

I agree with this plan of care while at school or attending school-sponsored functions.

Sign name: _____

Print name: _____

Date: _____

Student's last name and first initial: _____ RN's initials: _____ Date: _____ (page ___ of ___)