

Appendix E.7

Health Care Plan Period _____ to _____ Review date _____	INDIVIDUALIZED HEALTHCARE ACTION PLAN
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I. IDENTIFYING INFORMATION	
Student's name _____	School _____
Birthdate _____	Teacher _____
Age _____	Grade _____

CONTACTS

PARENT/GUARDIAN	
Mother's name _____	Home Phone _____
Address _____	Work Phone _____
Father's name _____	Home Phone _____
Address _____	Work Phone _____
PHYSICIAN	
Physician _____	Phone _____
Address _____	
HOSPITAL	
Hospital Emergency Room _____	Phone _____
Hospital Address _____	Phone _____
EMERGENCY MEDICAL SERVICES _____	

II. MEDICAL OVERVIEW
Medical Condition _____ Any Known Allergies _____
Medications _____
Possible side effects _____
Health care procedures needed at school _____

Appendix E.7 (continued)

III. OTHER SIGNIFICANT INFORMATION

- Emergency Action Plan on file
- Individual Health Plan on file

IV. BACKGROUND INFORMATION/NURSING ASSESSMENT

Brief Medical History

Special Health Care Needs

Social/Emotional Concerns

V. HEALTHCARE ACTION PLAN

Attach physician's order and protocol for any specialized procedure.

Student specific procedures/interventions

Procedure	Performed by	Equipment	Maintained by	Authorized/ trained by

Appendix E.7 (continued)

V. HEALTHCARE ACTION PLAN (cont.)		
Medications		
Dietary Needs		
Transportation Needs		
Classroom/School Modifications (including adaptive PE)		
Equipment – list necessary equipment/supplies	Provided by parent	Provided by school
<input type="checkbox"/> None required		
Safety measures		
Substitute/Back up (when primary caregiver is not available)		
Possible problems to be expected when performing procedure(s)		
Emergency Plan _____ Transportation Plan _____		

Appendix E.7 (continued)

VI. DOCUMENTATION OF PARTICIPATION

We have participated in the development of the Healthcare Action Plan and agree with its contents.

Signature _____ Date _____

_____ Administrator or Designee

_____ Parent

_____ Nurse

_____ Teacher

VII. PARENT AUTHORIZATION FOR SPECIAL HEALTH SERVICES

We (I), the undersigned who are the parent(s)/guardian(s) of _____
Birthdate _____, request and approve this Healthcare Action Plan. We (I), understand that a qualified person(s) will be performing the health care service. It is our understanding that in performing these services, the designated person(s) will be using the attached special care procedure protocol which has been approved by the student's physician and health care team.

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

We (I) agree to provide the following, if any: medication, medication equipment and supplies and dietary supplements requiring a prescription.

(Parent Signature)

Date _____

(Parent Signature)

Date _____