| **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*:*** | | | | | |
| 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 | |  |  | | |