

INDIVIDUAL HEALTH CARE PLAN (IHCP)

3418.1X
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Student _____ Grade _____ Birth Date _____ School _____
 Parent(s)/Guardian(s) _____ Home Phone _____
 Address _____ Work Phone _____
 Parent(s)/Guardian(s) _____ Home Phone _____
 Address _____ Work Phone _____
 Emergency Contact 1 _____ Relationship _____ Phone _____
 Emergency Contact 2 _____ Relationship _____ Phone _____
 Doctor _____ Phone _____ Hospital _____ Phone _____
 Medical Coupons Private Insurance

Brief History _____

Age at diagnosis _____ Recent hospitalization _____
 Concurrent illness/disability _____
 Social/emotional factors _____

PLAN

Daily Routine

Arrival time _____ Departure time _____ Transportation used _____
 Snacks _____ Times _____
 Recess considerations _____
 Treatment/Test times and locations _____
 Lunch time _____ Accommodations for lunch _____ PE days/times _____

Field Trips

Notify parent prior to trip
 Parent/parent-designated adult will accompany
 Follow specified plan developed for field trip _____

Classrooms/school parties

No restrictions
 Modify treats or activity _____
 Provide for additional testing/treatment _____

Scheduled after-school activities

List _____
 Provide for additional testing/treatment _____
 Follow specified plan developed for field trip _____

Testing/Treatment activities

Totally independent in testing, treatment and monitoring activities.
 Needs assistance with:
 Glucometer, finger stick _____ Verify numbers _____
 Insulin pen _____
 Ketone check _____
 Peak flow meter _____
 Nebulizer _____
 Epi-pen _____
 Dietary _____
 Other _____

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Equipment and supplies provided by parent: _____ _____ _____ _____ _____ _____ _____ _____	<p>Blood sugar meter kit (includes all blood testing supplies for school)</p> <p>Low blood sugar supplies: For example:</p> <ul style="list-style-type: none"> • fast-acting carbohydrate drinks: apple juice an/or orange juice and/or soda pop (regular, not diet)- 6-pack • glucose gel product • prepackaged snacks on hand, such as crackers with cheese or peanut butter, etc. <p>Daily snacks (for AM/PM snack)</p>	Disaster supplies (check): <input type="checkbox"/> Food supply for three (3) days stored in: _____ _____ <input type="checkbox"/> Low blood sugar supplies <input type="checkbox"/> Medication and medical supplies stored in _____ <input type="checkbox"/> Insulin pen and needles <input type="checkbox"/> Insulin and syringes <input type="checkbox"/> Other supplies (specify) _____
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Special instructions _____

Bus plan _____

The IHCP care plan will be reviewed annually unless changes occur during the school year.

Plan shared with Principal Office secretary Teacher Health Services Counselor
Kitchen Bus driver
Other _____

Initial date _____ Copy sent home

Parent(s)/Guardian(s)	Date	Nurse	Date
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Care plan review date _____ Copy sent home

Parent(s)/Guardian(s)	Date	Nurse	Date
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The following have been trained to carry out the plan:

1. _____
2. _____
3. _____