



Linda McCulloch, Superintendent  
 Office of Public Instruction  
 PO Box 202501  
 Helena, Montana 59620-2501  
 www.opi.state.mt.us

# Individualized Health Care Plan

## I. IDENTIFYING INFORMATION

Student's Name	School
Birthdate	Teacher
Age	Grade

## CONTACTS

### PARENTS

Mother's Name \_\_\_\_\_

Mother's Address \_\_\_\_\_

Mother's Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_ Emerg. Telephone \_\_\_\_\_

Father's Name \_\_\_\_\_

Father's Address \_\_\_\_\_

Father's Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_ Emerg. Telephone \_\_\_\_\_

### PHYSICIAN

Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Physician Address \_\_\_\_\_

### HOSPITAL

Hospital Emergency Room \_\_\_\_\_ Telephone \_\_\_\_\_

Hospital Address \_\_\_\_\_

Ambulance Service \_\_\_\_\_ Telephone \_\_\_\_\_

### SCHOOL

School Nurse \_\_\_\_\_ Telephone \_\_\_\_\_

## II. MEDICAL OVERVIEW

Medical Condition \_\_\_\_\_ Any Known Allergies \_\_\_\_\_

Medications \_\_\_\_\_

Possible Side Effects \_\_\_\_\_

Necessary Health Care Procedures at School \_\_\_\_\_

Health Care Plan for Period \_\_\_\_\_ to \_\_\_\_\_

**III. OTHER IMPORTANT INFORMATION**

**IV. BACKGROUND INFORMATION/NURSING ASSESSMENT**

Brief Medical History

Check if additional information is attached.

Specific Health Care Needs

Check if additional information is attached.

Social/Emotional Concerns

Check if additional information is attached.

Academic Achievement

Check if additional information is attached.

**V. HEALTH CARE ACTION PLAN**

Attach physician's order and other standards for care.

**Procedures and Interventions (student specific)**

Procedure	Administered by	Equipment	Maintained by	Auth/trained by
1.				
2.				
3.				

**V. HEALTH CARE ACTION PLAN (cont.)**

Medications

Attach medication form and administration log.

Diet

Check if additional information is attached.

Transportation

Check if additional information is attached.

Classroom School Modifications (including adapted PE)

Check if additional information is attached.

Equipment—List necessary equipment/supplies

Provided by Parent

Provided by District

1.

2.

3.

4.

None Required

Safety Measures

Check if additional information is attached.

Emergency Plan  Attached

Transportation Plan  Attached

Training Plan  Attached

Substitute/Backup Staff (when primary staff not available)

Possible Problems to be Expected

Training

**VI. HEALTH CARE PLAN REVIEW**

Next review date of Health Care Plan \_\_\_\_\_

**VII. DOCUMENTATION OF PARTICIPATION**

We have participated in the development of the Health Care Plan and agree with its contents.

Signature

Date

_____	Administrator or Designee
_____	Teacher
_____	Nurse
_____	
_____	

**VIII. PARENT AUTHORIZATION FOR SPECIAL HEALTH SERVICES**

We (I), the undersigned who are the parents/guardians of \_\_\_\_\_, \_\_\_\_\_  
(Student Name) (Birthdate)

request and approve the attached Individualized Health Care Plan. We (I) understand that a qualified designated person(s) will be performing the health care service. It is our understanding that in performing this service, the designated person(s) will be using a standardized procedure which has been approved by the student's Health Care Team and Physician.

We (I) will notify the school immediately if the health status of \_\_\_\_\_  
(Student Name)

changes, we change physicians, or there is a change or cancellation of the procedure.

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

\_\_\_\_\_  
Parent Signature

Date \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

Date \_\_\_\_\_



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# EMERGENCY HEALTH CARE PLAN

Student's Name	Date
Physician	Phone
Preferred Hospital	

### STUDENT SPECIFIC EMERGENCIES

IF YOU SEE THIS	DO THIS

### IF AN EMERGENCY OCCURS

1. If the emergency is life-threatening, immediately call 9-1-1.
2. Stay with the student or designate another adult to do so.
3. Call or designate someone to call the principal and/or health care coordinator.
  - a. State who you are
  - b. State where you are
  - c. State problem
4. If the nurse is unavailable, the following staff members are trained to deal with an emergency, and to initiate the appropriate procedures:

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## Transportation Plan for Student with Special Health Care Needs

Student's Name		School	
Address		Grade	Home Phone
Parent/Guardian Name		Work Phone (Father)	Work Phone (Mother)
Receives Medications    Yes <input type="checkbox"/> No <input type="checkbox"/>		Possible Side Effects	

**I. ADAPTATIONS/ACCOMMODATIONS REQUIRED    YES     NO**

- Transportation aide
- Bus lift
- Seat belt
- Wheel chair tie downs
- Space for equipment—Identify equipment \_\_\_\_\_  
 \_\_\_\_\_

**II. POSITIONING OR HANDLING REQUIREMENTS    YES     NO**

Describe

**III. BEHAVIOR CONSIDERATIONS    YES     NO**

Describe





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## Personnel Training Plan for Student with Special Health Care Needs

Identify Personnel to be Trained:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Focus of Training \_\_\_\_\_

Instructor \_\_\_\_\_

Date of Training \_\_\_\_\_

Describe Training to be Provided:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Recommendation for follow-up review \_\_\_\_\_

Identify Personnel to be Trained:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Focus of Training \_\_\_\_\_

Instructor \_\_\_\_\_

Date of Training \_\_\_\_\_

Describe Training to be Provided:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Recommendation for follow-up review \_\_\_\_\_

Identify Personnel to be Trained:

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Focus of Training \_\_\_\_\_

Instructor \_\_\_\_\_

Date of Training \_\_\_\_\_

Describe Training to be Provided:

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Recommendation for follow-up review \_\_\_\_\_

Identify Personnel to be Trained:

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Focus of Training \_\_\_\_\_

Instructor \_\_\_\_\_

Date of Training \_\_\_\_\_

Describe Training to be Provided:

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Recommendation for follow-up review \_\_\_\_\_



