**RICHMOND CITY PUBLIC SCHOOLS HEALTH SERVICES**
**Individualized Health Care Plan***

Date: _____

Dear Health Care Provider,

Richmond City Public Schools needs you to review and complete the enclosed Individualized Health Care Plan (IHCP)

For: _____.
**(Student's Name and Date of Birth)**

Please review, complete and sign the attached IHCP and additional, required forms. These signed forms are required before this student can attend school. If you have any questions or concerns, please feel free to call me.

Thank you for your assistance.

_____
**(School Nurse)**

_____
**(Phone Number)**

_____
**(Fax Number)**

**Forms Attached:**

- ☐ Medication Permission Form
- ☐ Allergy Action Plan
- ☐ Asthma Action Plan
- ☐ Seizure Action Plan
- ☐ Procedures to be performed at School Form
- ☐ Physician's Statement for Students with Special Dietary Needs Form
- ☐ Safe Feeding at School Form
- ☐ Tube Feeding at School Form

**RICHMOND CITY PUBLIC SCHOOLS HEALTH SERVICES**
**Individualized Health Care Plan***

**School Year: _____**

**STUDENT DATA:**
**Student's Name: _____ Gender: _____ DOB: _____**
**School: _____ Grade: _____**

**Parent/Guardian(s) responsible for health care decisions: ☐Mother ☐Father ☐Legal Guardian ☐Other_____**
**Name(s):_____**
**Address: _____**
**Phone: (H)_____ (C)_____ (W)_____**

**Emergency Contact Information:**
**Name: _____ Relationship to student:_____**
**Phone: (H)_____ (C)_____ (W)_____**

**Physician Information:**
**Primary Care Provider Name: _____**
**Address: _____**
**Phone: _____ Fax:_____**

**Specialist: _____**
**Address: _____**
**Phone: _____ Fax: _____**

**Medical Information:**
**Diagnosis: _____**

**ALLERGIES: _____**
**History of Medical Conditions- Include date of onset and most recent concerns: _____**
_____
_____
_____
_____

**Medications currently taking at home:**
_____ _____ _____
_____ _____ _____
_____ _____ _____

**Medications to be administered at school:**

| MEDICATION NAME | DOSE | ROUTE | FREQUENCY | TIME |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**RICHMOND CITY PUBLIC SCHOOLS HEALTH SERVICES**
**Individualized Health Care Plan***

| | | | | |
|---|---|---|---|---|
| | | | | |

**Student Name:** _____ **DOB:** _____

**PROCEDURES TO BE PERFORMED AT SCHOOL:**

- ☐ Oral Feeding *
- ☐ Tube Feeding *
- ☐ Tube Site Care
- ☐ Trach Care*
- ☐ Ventilator Care*
- ☐ Seizure Monitoring*
- ☐ Other*: _____
- ☐ Mobility Assistance
- ☐ Wound Care
- ☐ Toileting assistance and hygiene care
- ☐ Urinary Cath
- ☐ Colostomy Care
- ☐ Oxygen

***If above checked, please complete attached forms.**

**Equipment needed during school hours (i.e. oxygen, ventilator, suctioning):**

_____

**Nutrition:**

- ☐ Oral Feeding with No Dietary Restrictions (no further orders needed)
- ☐ Oral Feeding with Dietary Restrictions- see attached **"Physician's Statement for Students with Special Dietary Needs"**
- ☐ Swallowing concerns- see attached **"Safe Feedings at Schools"**
- ☐ Tube Feeding- see attached **"Physician's Orders for Tube Feeding"**

**Mobility:**

☐ Independent ☐ Needs assistance ☐ Other: _____

Uses the Following:

☐ Wheelchair- Type: _____ ☐ Crutches ☐ Prosthetic or orthopedic appliances: _____

**Toileting:**

☐ Independent ☐ Toileting assistance_____ ☐ Diaper changes and care: _____

☐ Other: _____

**Urinary Cath:** Frequency/Schedule:

- ☐ Student is independent in self cath and needs no assistance
- ☐ Student needs assistance with cath
- ☐ Catheter size & instructions:_____ ☐

Other:_____

**Other Procedures /Specific Instructions:** _____

_____

**Please Note:** A Nurse is NOT always in the school building and trains non-medical staff to administer medication and perform specific procedures. It is the Parent/Guardian responsibility to furnish all equipment, supplies, medication, or other items necessary for care during the school day.

**Physician Name (printed):**_____ **Phone:** _____

**Physician Signature:** _____ **Date:** _____

**Parent/Guardian Signature:** _____ **Date:** _____

## RELEASE FORM

### Parent/Guardian Statement

I, the undersigned Parent/Guardian of _____, hereby request the School Nurse or trained staff member to administer the procedures and medication (s) outlined in the above care plan according to the Physician's Orders.

I understand that it is the Parent/Guardian responsibility to furnish all equipment, supplies, medication, or other items necessary for the administration of the service/procedure and to provide replacement and maintenance as necessary.

Equipment supplied by parents:

_____

_____

_____

I authorize that a representative of the school and the listed health care provider to exchange information regarding the medical condition of this student and the treatments/procedures ordered in this Health Services Plan.

I understand and agree to comply with the school's policies and procedures as listed in the Student Code of Responsible Ethics (SCORE). The Health Services Plan is confidential and may be shared on a need to know basis where appropriate. Privacy and confidentiality of the student and family will be respected and preserved.

I agree to notify the School Nurse immediately if there are any changes in the student's status or Physician's orders.

**Parent/Guardian Signature: _____ Date: _____**

**Printed Name: _____ Contact Phone: _____**

**Reviewed by School Nurse: _____ Date: _____**

**Phone Number: _____ Fax Number: _____**

**RICHMOND CITY PUBLIC SCHOOLS HEALTH SERVICES**
**Individualized Health Care Plan***

Emergency Care Plan (or Emergency Action Plan)

To be completed by Health Care Provider

Student Name_____Class/Grade_____

Phone Parent/Guardian _____Phone _____

Phone Parent/Guardian _____Phone _____

Healthcare Provider_____ Phone_____

| **If you see this** | **Do this** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

In an emergency occurs:

1. Stay with child
2. Call or have someone else call the school nurse
3. If the school nurse is not available, the following staff members are trained to initiate the emergency care plan:

_____

_____

_____