### Cystic Fibrosis Individualized Healthcare Plan (IHCP)

**Student:** __________________________________   **ID#:_____________________**

**Grade:** __________________  **DOB:** __________________  **Teacher:** ____________________________

**Allergies:** __________________________________________

**Student’s Secondary Health Concerns:** __________________________________

**Nursing Diagnosis:** Knowledge Deficit Related to Disease Management & Prescribed Treatment Regimen (NANDA 00126)

**Student Goal:** Student Will Demonstrate Understanding of the Disease Process and Management. Student will comply with preventive measures to prevent complications.

**Ratings:** 1- No Knowledge, 2- Limited, 3- Moderate, 4- Substantial, 5- Extensive Knowledge, N/A- Not Applicable (Circle One)

**Student Knowledge: Disease Process**

| Date: | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A |
| Describe the disease process | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A |
| Able to Describe Common Signs & Symptoms of the Disease | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A |
| Describe Potential Complication of Disease | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A |
| States interventions that can be taken to effectively manage disease | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A |
| Verbalizes Lifestyle Changes that may be Required to Prevent/Control Future Complications of Disease | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A |

**Student Knowledge: Treatment Management**

| Date: | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A |
| Knowledge of Treatment Regimen | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A |
| Verbalizes Understanding on When to Use Prescribed Medication | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A |
| Knows When to Seek Medical Attention/Emergency Treatment | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A |
| Understands treatment effectiveness | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A |
| Routinely monitors expiration date | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A | 1 | 2 | 3 | 4 | 5 | N/A |
### Student Knowledge: Medication Administration

| Identification & Correct Name of Medication | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A |
| Correct Use of Prescribed Medication (Correct Dose, Time, Route) | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A |
| Able to Verbalize Medication Side Effects | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A |
| Confidence Performing Needed Task | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A |

Ratings: 1- Severely Compromised, 2- Substantially, 3- Moderately, 4- Mildly, 5- Not Compromised, N/A- Not Applicable (Circle One)

### RN Assessment of Student Health Status

| Physical Health | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A |
| Mental Health | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A |
| School Attendance | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A |
| Readiness to Learn | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A |
| Participation In Physical Activities | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A |
| Healthy Dietary Habits | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A | 1 2 3 4 5 N/A |

Completed by:  
Completed by:  
Completed by:  
Completed by:  

Nurse's Signature:  
Nurse's Signature:  
Nurse's Signature:  
Nurse's Signature:  

*Emergency Action Plan Available in Medication Binder, UAP & Student Checklists Completed by RN

### Additional Notes:

_________________________________________________________________________________  
_________________________________________________________________________________  
_________________________________________________________________________________  
_________________________________________________________________________________
### Roles and Responsibilities: Cystic Fibrosis

**Student:**
- DOB: 
- ID#: 
- Grade: 

**Parent/Guardian Name:**

**Teacher:**

**School:**

**School Year:** 2019-2020

<table>
<thead>
<tr>
<th>School Responsibilities/Agreements</th>
<th>Family Responsibilities/Agreements</th>
<th>Student Responsibilities/Agreements</th>
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<tbody>
<tr>
<td>1. Medication is kept:</td>
<td>1. Provide medication for school site.</td>
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<tr>
<td>Circle below where applicable-</td>
<td>Pick up and replace any expired</td>
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<tr>
<td>Clinic</td>
<td>medication. Med Name &amp; Exp. Date:</td>
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<tr>
<td>Main Office</td>
<td>Med Name &amp; Exp. Date:</td>
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<td>Classroom</td>
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<td>Student</td>
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<tr>
<td>Other:</td>
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<td>1. Take medication at appropriate time or</td>
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<td>2. Report to health office at appropriate time for medications.</td>
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<td>2. UAP to administer medications per</td>
<td>2. Keep school staff informed of any changes in student condition,</td>
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<td>MDCPS training:</td>
<td>medications and updated emergency contact information. Any change in medication regimen requires new medication forms.</td>
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<td>Report any early warning signs to an adult as soon as possible.</td>
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<td>3. Staff to contact 911/parent/guardian in case of an emergency: Administration</td>
<td>3. Available to accompany student on field trip and carry the medication.</td>
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<td>4. Staff to direct EMS to the emergency: Administration &amp; Security</td>
<td>4. Pick up any unused medication at the end of the school year.</td>
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<td>5. CPR certified staff:</td>
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<td>6. Security/Teacher to carry school two-way radio and/or have emergency intercom access</td>
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<td>7. Substitute teacher instructions: On Lesson Plan</td>
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Parent/Guardian Signature: __________________________ Date: ____________

Principal or School Administration Designee: __________________________ Date: ____________

School Nurse: __________________________ Date: ____________
8020 & 8080
Child-Specific Training for School Staff
August 20____ - June 20____

School: ______________________

Student: ______________________ Date_______
ID # ______________________
DOB: ______________________
Health Condition: ________________

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<thead>
<tr>
<th>Teacher Name</th>
<th>Subject</th>
<th>Signature</th>
<th>Level 2</th>
<th>Level 3</th>
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School Nurse: ______________________