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)

Date:_______________ Date:_______________ Date:_______________ Date: ____________

Student Knowledge: Disease Process

	Date	Date	Date	Date
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	Date	Date	Date
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: ____

FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE COUNTY
SCHOOL HEALTH PROGRAM
ROLES AND RESPONSIBILITIES: Cystic Fibrosis

Student:_______________________________**DOB:**_____________**ID#:**_______________**Grade:** _________
Parent/Guardian Name:_____________________________________**Teacher:** _________________________
School:____**School Year: 2019-2020**

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

___________________________________ ____________________
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:________________

Teacher Name	Subject	Signature	Level 2	Level 3

School Nurse:_____________________________