Individualized Healthcare Plan (IHCP)

Student:____ID#: __________________
Grade:______________DOB:________________Teacher: ______________________________
Allergies: ____
Student's Secondary Health Concerns: ____

Nursing Diagnosis: **Student Goal**:

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

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
Understands the factors that improves/ worsens pain	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
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

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: SICKLE CELL

Student:________________________________**DOB:**______________**ID#:**________________**Grade:** _________
Parent/Guardian Name:______________________________________**Teacher:** _________________________
School:____**School Year:** __________________

School Responsibilities/Agreements	Family Responsibilities/Agreements	Student Responsibilities/Agreements
1. Medication is kept: Circle below where applicable- Clinic Main Office Classroom Other:_____________	1. Provide medication for school site. Pick up and replace any expired medication. Med Name & Exp. Date: ________________________________ Med Name & Exp. Date: ________________________________	1. Report early warning signs of sickle cell episode to school staff.
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.	
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:_