Impaired Nutrition Individualized Healthcare Plan (IHCP)

Student:______________________________ID#: __________

Grade:____________DOB:______________Teacher: ____________________

Allergies: ____

Student's Secondary Health Concerns: ______________________________

Nursing Diagnosis: Sedentary Lifestyle (NANDA 00168)

Readiness for enhanced nutrition (NANDA 00163); Imbalanced nutrition (NANDA 00001& 00002)

Student Goal: Student will develop healthy lifestyle habits by eating healthy and engaging in daily physical activities to maintain his/her BMI within narmal range.

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

Student Knowledge: Impaired Nutrition

	Date:__________	**Date: __________**	**Date: __________**
Understands factors that lead to weight gain	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 having impaired nutrition/sedentary lifestyle.	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 achieve ideal BMI and reduce risk for disease	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

Identifies cause of weight loss	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Initiates plan for increasing activity level and establish routine exercise	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
understands how to read nutrition labels and choose healthy options	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Understands portion control	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

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
Mental Health	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
Readiness to Learn	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
Healthy Dietary Habits	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:**
	Nurse's Signature:	**Nurse's Signature:**	**Nurse's Signature:**

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

Evaluation of Effectiveness	Date: ______________	Date: ______________	Date: ______________
Uses diary to monitor food and fluid intake	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Increased servings of fruits and vegetables	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Reduced sugary beverages and increased water intake	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Increased activity level by adhering to exercise routine	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Improvement in Body Mass Index	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:**
	Nurse's Signature:	**Nurse's Signature:**	**Nurse's Signature:**

Additional Notes: ____

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

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:_