Sickle Cell 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:_____	**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: _____

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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:_