Cardiac Individualized Healthcare Plan (IHCP)

Student: _____ ID#: _____
Grade: _____ DOB: _____ Teacher: _____
Allergies: _____
Student's Secondary Health Concerns: _____

Nursing Diagnosis: Deficient Knowledge related to disease process and disease management (NANDA 00126) & Risk for Activity Intolerance (NANDA 00094)

Student Goal: Student will demonstrate understanding of the disease process and management. Student will comply with preventive measures to avoid complications of disease.

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: _____**
Understands 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, including energy limitations	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
Knows Importance of Continual Access to Emergency 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
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	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

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

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 & RESPONSIBILITIES - CARDIAC CONDITION

Student: _____ DOB_____ Teacher: _____ Grade: _____
Parent/Guardian & Phone(s): _____ School Year: _____

Follow the attached physician action plan; if no plan submitted, call 911 and parent/guardian.

School Responsibilities/Agreements	Family Responsibilities/Agreements	Student Responsibilities/Agreements
1. Medication Kept: _____ _____ _____	1. Provide medication authorization and correctly labeled medication for school site at beginning of school year/annually and as necessary.	1. Report early warning signs of cardiac distress
2. Trained staff to administer medications per Authorization for Medication: _____ _____	2. Inform school staff ASAP of any changes to medications Provide NEW medication authorization and labeled medication Replace expired medications ASAP	Most common symptoms: 1. Chest discomfort 2. Shortness of breath 3. Sweating, nausea, vomiting, or dizziness
3. Staff to contact 911/parent/guardian: _____ _____	3. Inform school staff ASAP of any changes in student's condition/limitations	
4. Staff to direct EMS to the emergency: _____ _____ _____	4. Parent or designated adult, as noted on emergency alert card, to respond to school when called. 5. Maintain current and up to date phone numbers.	
5. CPR certified staff : _____ _____		
6 Substitute teacher instruction 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:_____