Elkhart and St. Joseph Counties Head Start Consortium, 245 North Lombardy Drive, Suite A, South Bend, IN 46619

Individualized Health Care Plan

A SIGNED "MEDICATION AT SCHOOL FORM(S)" MUST BE ON FILE

Concern: _____ **Date:** ____/____/____

Student's Name: _____ **D.O.B.:** ____/____/____

Parent(s): _____ **School Year:** _____

Site: _____ **Classroom:** _____ **Teacher:** _____

Home Phone: _____ **Alternate Number:** _____

Emergency Contact: _____ **Phone Number:** _____

Doctor's Name: _____ **Phone Number:** _____

Action Plan from Health Care Provider is Attached: Yes ☐ No☐

A. MEDICATIONS BEING TAKEN AT HOME

"Quick Relief" or "As Needed" Medication(s) _____

Long-term Control or Daily Medication(s) _____

Other Medication(s) _____

B. MEDICATIONS TO BE TAKEN AT SCHOOL

Name of Medication(s): _____

Dosage: _____

Instructions for Administration: _____

Side Effects: _____

When to Call the Health Provider: _____

Medications are kept safely in the following designated area: _____

COMPLETE THE FOLLOWING QUESTIONS WITH THE FAMILY:

1. When was the child diagnosed?
2. Who are the health care providers involved in the management of the child's health concern?
3. Has the child had any severe episodes that required:
   a. An Emergency Room Visit?
      _____Yes _____ No
      If yes, how often? _____
   b. An overnight stay in the hospital?
      _____ Yes _____ No
      If yes, how often? _____
   c. Missed days from school?
      _____ Yes _____ No
      If yes, how often? _____

Signs and Symptoms of a Possible Episode:

These are possible signs and symptoms of an episode:

- Child appears to be in distress
- Difficulty breathing
- Persistent coughing
- Wheezing
- Tightness in the chest
- Anxiety or restlessness
- Pale color
- Child appears to be "working too hard" to breathe
- Child tell you he/she needs his asthma medication
- Any of these symptoms that increase with exercise

Other signs, symptoms, or warning signs for this child:

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-
-
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Date Prepared: _____ **Date Reviewed:** _____

Parent's Agreement: I agree with this Individualized Care Plan:

Parent/Guardian Signature: _____ Date: _____

Staff Signature/Title when IHP has been reviewed	Date	Staff Signature/Title when IHP has been reviewed	Date
Teacher: _____	_____	**Bus** _____	_____
Teacher Asst.: _____	_____	**Bus** _____	_____
FACS: _____	_____	_____	_____
Para: _____	_____	_____	_____

Head Start Nurse: _____ **Date:** _____