(Health Care Coordinator)

(Education Coordinator)

Health Care Plan Checklist

Student Information:

(Name) (Birthdate)

(Parent/Guardian) (Address)

Mother ( ) (Home) ( ) (Work)

Father ( ) (Home) ( ) (Work)

(School) (Grade)

Preparation for Entry:

- ☐ Home Visit (Date)
- ☐ Medical History (Date)
- ☐ Planning Meetings (Date) (Date) (Date)
- ☐ Staff Training Meetings (Date) (Date) (Date)
- ☐ Educational Team Meeting (Date)

Health Care Plan:

Doctor's Order (Date)

Child-Specific Procedural Guidelines (Date)

Emergency Plan (Date)

Health Care Plan Included in Child's Record: (Date)

Child-Specific Care-giver Training (Skills Checklist) (Date)

Next Training Review (Date)

Health Care Plan Included in IEP: (Date)

Name ______________________ **Date** __________

Important Personnel

Primary Health Care Providers	Telephone Number

School Contacts

	Training	
Direct Care-Givers	Child-Specific	General
Substitute Care-Givers		
Back-up Staff		

Child-Specific Training Done By

______________________ ______________________ (Date)

General Staff Training Done By

______________________ ______________________ (Date)

Name ______________________ Date ______________

Background Information

Brief Medical History: ______________________

Special Health Care Needs of the Child: ______________________

Baseline Status: ______________________

Medication: ______________________

Diet: ______________________

Transportation Needs: ______________________

Name ______________________ **Date** ____________

Procedure: ______________________________

Frequency: ______________________ Times: ____________

Position of student during procedure: ______________________

Ability of the student to assist/perform procedure: ______________________

____

Suggested setting for procedure: ______________________

Equipment:

Daily: ______________ Emergency: ______________

Checked by: ______________ Checked by: ______________

Storage: ______________ Storage: ______________

Maintenance: ______________ Maintenance: ______________

Home Care Co: ______________ Phone: ______________

Child-specific techniques and helpful hints: ______________________

____

Special considerations and precautions: ______________________

____

Name ______________________ **Date** __________

Possible Problems

Observation	Reason	Action

Health Care Plan:

Written and Submitted By: ______________________________
(Name) (Date)

Reviewed and Signed By:

Parent/Guardian & Student ______________________________
(Name) (Date)

____
(Name) (Date)

Administrator: ______________________________
(Name) (Date)

Physician: ______________________________
(Name) (Date)

Next Review and Revision of Health Care Plan:

Date: ______________________

Health Care Plan should be revised according to child's specific needs.

Emergency Information

Name: ______________________ Birthdate ______________

Address: ______________________ Telephone ______________

____

Mother: ______________ Work: ______________ Home: ______________

Father: ______________ Work: ______________ Home: ______________

Other contact: ______________________ Phone: ______________

Emergency Numbers:

EMT: ______________________ Telephone ______________

Fire: ______________________ Telephone ______________

Police ______________________ Telephone ______________

Home Care Co.: ______________________ Telephone ______________

Ambulance: ______________________ Telephone ______________

Gas Co.: ______________________ Telephone ______________

Electric: ______________________ Telephone ______________

Preferred Hospital:

______________________ Telephone ______________

Local Hospital Emergency Room:

______________________ Telephone ______________

Primary
Physician: ______________________ Telephone ______________

Dentist: ______________________ Telephone ______________

Specialists:

______________________ Telephone ______________

______________________ Telephone ______________

______________________ Telephone ______________

______________________ Telephone ______________

______________________ Telephone ______________

Emergency Plan

Name: ____________________

Date: ____________________

Child-Specific Emergencies:

If You See This	Do This

If an emergency occurs:

1. Stay with child.
2. Call or designate someone to call the nurse.
   State who you are:
   State where you are:
   State problem:
3. The school nurse will assess the child and decide whether the emergency plan should be implemented.
4. If the school nurse is unavailable, the following staff members are trained to deal with an emergency, and to initiate the emergency plan:

____

____

____

____

Name: ______________________________

Emergency Telephone Procedure:

1. Dial 911 and/or designated ambulance company.

2. State who you are—"I am ______________________________ a nurse/teacher/ para-professional in the ______________________________ school."

3. State where you are:

   School name: ______________________________

   Address: ______________________________

   City: ______________________________

4. State what is wrong with child.

5. Give specific directions: (e.g., which school entrance should be used, location of child).

6. Don't hang up. Ask for the information to be repeated and provide any other necessary information. Hang up when all information has been received and is correct.

7. **Notify:**

   a. School principal or school official in charge of the building at that time
   #______________________________

   b. School back-up personnel ______________________________

   State:

   Emergency plan for ______________________________ is in effect.

   The student is located ______________________________

8. **The school official will:**

   a. Meet the EMTs.

   b. Direct EMTs to the emergency area.

   c. Call parents and other necessary individuals (including physician).

   An adult should be designated to accompany the child in the ambulance.

   Hospital that the child should be transported to ______________________________.

Daily Log

Name ______________________ **School** ______________________

Procedures ____

Parent ______________________ **Phone** ______________________

Date/Time	Procedure Notes	Observations	Name

Physician's Order for Specialized Health Care Procedure

Student's Name: ______________________ Birthdate: ______________

Address: ____

Procedure: ____

____

☐ I have reviewed the Health Care Plan and approve of it as written.

☐ I have reviewed the Health Care Plan and approve of it with the attached amendments.

☐ I do not approve of the Health Care Plan. A substitute plan is attached.

Other recommendations: ________________________________

____

____

____

____

Duration of the Procedure: ______________________________
(Date)

Physician's Signature: ______________________ Date: ______________

Address: ____

______________________________________ Phone: ______________

Adapted with permission from: Pupil Personnel Services, Recommended Practices and Procedures Manual, Illinois State Board of Education, 1983

Parent Authorization for Specialized Health Care

We (I), the undersigned, who are the parents/guardians of

____ ________________

(Name) (Birthdate)

request that the following health care service(s) ________________________________

____

be administered to our child. We understand that a qualified designated person(s) will be performing the above-mentioned health care service. It is our understanding that in performing this service, the designated person(s) will be using a standardized procedure which has been approved by our physician.

____

(Name) (Address) (Phone)

We will notify the school immediately if the health status of ________________________
changes, we change physicians, or there is a change or cancellation of the procedure.

We understand that the above procedure should be scheduled before or after school hours whenever possible.

Signature of parents/guardians ____

____

Address: ____

Phone: (Home) __________________________ (Work) __________________________

__________________________ __________________________

Date: ______________________________

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