
(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:

<input type="checkbox"/> Home Visit	(Date)			
<input type="checkbox"/> Medical History	(Date)			
<input type="checkbox"/> Planning Meetings	(Date)	(Date)	(Date)	
<input type="checkbox"/> Staff Training Meetings	(Date)	(Date)	(Date)	
<input type="checkbox"/> Educational Team Meeting	(Date)			

Health Care Plan:

Doctor's Order	(Date)	Child-Specific Care-giver Training (Skills Checklist)	(Date)
Child-Specific Procedural Guidelines	(Date)	Next Training Review	(Date)
Emergency Plan	(Date)	Health Care Plan Included in IEP:	(Date)
Health Care Plan Included in Child's Record:	(Date)		

Name _____ Date _____

Important Personnel

Primary Health Care Providers

Telephone Number

School Contacts

Direct Care-Givers

Training
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: _____

Storage: _____

Maintenance: _____

Home Care Co: _____

Checked by: _____

Storage: _____

Maintenance: _____

Phone: _____

Child-specific techniques and helpful hints: _____

Special considerations and precautions: _____

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 _____

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: _____

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: _____
