Individualized Healthcare Plan (IHP) Core Form

An Individualized Healthcare Plan (IHP) should be developed by the parents/guardian, school nurse, student and other pertinent school officials. This plan needs to be reviewed and revised on a yearly basis or more frequently as health issues change. This plan should be attached to the student's IEP or 504 Plan, if applicable.

A copy of the Individualized Heath Care Plan must be given to the student's parent/guardian.

STUDENT'S INFORMATION

Name:				Date of Birth:	
Address:				City, State, Zip:	
School:		Grade:		Primary Language:	

PARENT/GUARDIAN INFORMATION

Child resides with: *Mother* ☐ *Father* ☐ *Both* ☐

Mother/Guardian						Father/Guardian					
Name:						Name:					
Address (if different):						Address (if different):					
Primary Language:						Primary Language:					
Phone:	(H)		(W)		(C)	Phone:	(H)		(W)		(C)

OTHER EMERGENCY CONTACT INFORMATION

Name:						Name:					
Relationship to Student:						Relationship to Student:					
Phone:	(H)		(W)		(C)	Phone:	(H)		(W)		(C)

HEALTH CARE PROVIDER INFORMATION

Preferred Hospital:

Primary Care Physician			Specialty Care Provider		
Name:		Date of Last Exam:	Name:		Date of Last Exam:
Phone:			Phone:		
Specialty Care Provider			**Specialty Care Provider**		
Name:		Date of Last Exam:	Name:		Date of Last Exam:
Phone:			Phone:		

IHP Supplements:

☐ Crisis Plan *(recommended)* ☐ Medication *(recommended)* ☐ Hospitalization & Insurance

☐ Equipment & Staff Training Needs ☐ Transition Action Plan

STUDENT'S HEALTH CARE INFORMATION

Primary Diagnosis:			
Other Diagnoses:			
Allergies: *list both food and medication allergies*			

POTENTIAL PROBLEMS

Triggers	Signs of Problems

TREATMENT PLAN – *List possible interventions or treatments that may take place during the school day.*

Interventions	Treatments
Person Responsible for Implementation and Documentation:	

Team Review – *Each team member should Initial and date after review of completed plan.*

☐ School Nurse_____ ☐ Parent/Guardian_____ ☐ Other *(specify)*_____

☐ Student _____ ☐ Healthcare Provider _____ *Name:*_____ *Phone:*_____

This document was developed by the Kansas Children and Youth with Special Health Care Needs program through the D70MC12837 grant funded by the U.S. Department of Health & Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.

Crisis Plan

IHP Supplement **Student Name:**

It is recommended that this document be attached to the student's Individualized Healthcare Plan (IHP).This form should be shared with all individuals who work with the student (including teachers, bus drivers, support staff, etc). This crisis plan should be developed by the parents/guardian, school nurse, student and other pertinent school officials. This plan needs to be reviewed and revised on a yearly basis or more frequently as health issues change. This plan can also be attached to the student's IEP or 504 Plan, if applicable.

CRISIS SITUATIONS	
If this occurs: *Define specific behaviors/conditions*	**Do this:** *Define intervention steps*

EMERGENCY SITUATIONS

1. **Call 911**
2. **Designate an adult to stay with the student – clear area of any potential risk factors to the student**
3. **Call the school nurse, principal or other designated personnel to assist**
4. **If the event occurs in an area where other students are present- have a designated adult lead them to another room**
5. **Contact parent/guardian**

OTHER STEPS: List any other emergency steps to follow based on student's special health care needs.

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Medication List

IHP Supplement **Student Name:**

It is recommended that this document be attached to the student's Individualized Healthcare Plan (IHP). This medication list should be developed by the parents/guardian, school nurse, student and other pertinent school officials. This plan needs to be reviewed and revised on a yearly basis or more frequently as health issues change. This plan can also be attached to the student's IEP or 504 Plan, if applicable.

CURRENT MEDICATIONS

Medication Name:				***Administered during school day? Yes ☐ No ☐***			
Reason for taking:				Possible Side Effects:			
Dosage:		Frequency:		Method of Admin:		Date Started:	
Medication Name:				***Administered during school day? Yes ☐ No ☐***			
Reason for taking:				Possible Side Effects:			
Dosage:		Frequency:		Method of Admin:		Date Started:	
Medication Name:				***Administered during school day? Yes ☐ No ☐***			
Reason for taking:				Possible Side Effects:			
Dosage:		Frequency:		Method of Admin:		Date Started:	
Medication Name:				***Administered during school day? Yes ☐ No ☐***			
Reason for taking:				Possible Side Effects:			
Dosage:		Frequency:		Method of Admin:		Date Started:	
Medication Name:				***Administered during school day? Yes ☐ No ☐***			
Reason for taking:				Possible Side Effects:			
Dosage:		Frequency:		Method of Admin:		Date Started:	
Medication Name:				***Administered during school day? Yes ☐ No ☐***			
Reason for taking:				Possible Side Effects:			
Dosage:		Frequency:		Method of Admin:		Date Started:	

MEDICATION ALLERGIES OR AVERSIONS

Medication	Reaction	What to do in case of accidental administration

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Hospital Admissions & Insurance Information

IHP Supplement **Student Name:**

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HOSPITAL ADMISSIONS (Within the past 12 months)

Date:		Reason:		Date:		Reason:	
Outcome:				Outcome:			
Date:		Reason:		Date:		Reason:	
Outcome:				Outcome:			
Date:		Reason:		Date:		Reason:	
Outcome:				Outcome:			
Date:		Reason:		Date:		Reason:	
Outcome:				Outcome:			
Date:		Reason:		Date:		Reason:	
Outcome:				Outcome:			
Date:		Reason:		Date:		Reason:	
Outcome:				Outcome:			
Date:		Reason:		Date:		Reason:	
Outcome:				Outcome:			

INSURANCE INFORMATION

Primary Insurance		Secondary Insurance	
Name:		Name:	
Policy #:		Policy #:	

Kansas Department of Health and Environment

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FAMILIES TOGETHER, INC.

Equipment and/or Staff Training Needs

IHP Supplement **Student Name:**

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EQUIPMENT NEEDED

Type:		Describe Use:	
Maintenance:		Staff Trained:	
Type:		Describe Use:	
Maintenance:		Staff Trained:	
Type:		Describe Use:	
Maintenance:		Staff Trained:	

STAFF TRAINING

Training Needed:			***Date Completed:***
Who will conduct training?		Frequency of Training:	
Training Needed:			***Date Completed:***
Who will conduct training?		Frequency of Training:	

Staff Trained:

Name: _____ Signature: _____

Name: _____ Signature: _____

Name: _____ Signature: _____

Name: _____ Signature: _____

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Transition Action Plan

IHP Supplement **Student Name:**

This transition action plan should be developed by the parents/guardian, school nurse, student and other pertinent school officials. This plan needs to be reviewed and revised on a yearly basis or more frequently as needs change. This plan can also be attached to the student's IEP or 504 Plan, if applicable.

TRANSITION GOAL:	
Step 1:	**Support Needed:**
	Resources:
Step 2:	**Support Needed:**
	Resources:
Step 3:	**Support Needed:**
	Resources:
TRANSITION GOAL:	
Step 1:	**Support Needed:**
	Resources:
Step 2:	**Support Needed:**
	Resources:
Step 3:	**Support Needed:**
	Resources:

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