**Germantown Municipal School District**

**Individualized Healthcare Plan**

**School Year: 20\_\_\_\_-20\_\_\_\_**

Student Name: Date of Birth: SSN: Sex:

School: Phone: Grade: Teacher:

Address: City/State: Zip:

Mother: Home Phone: Work Phone:

Father: Home Phone: Work Phone:

Emergency Contacts (Include Relationship)

1. Phone: Relationship:
2. Phone: Relationship:

Primary Health Concern (Medical Diagnosis):

Secondary Health Concern(s):

Definition of primary health concern:

MD Orders for:

New Orders due:

Glucagon exp. EpiPen exp. Diastat exp.

Hospital: Phone:

Insurance: Case Manager: Phone:

Supply/Equipment Vendor: Contact:

Physician(s):

1. Phone:
2. Phone:
3. Phone:

Medication(s) at School (List time and dosage) Medication(s) at Home (List time and dosage)

***Nursing Diagnoses:***

***Goals:***

***Interventions:***

***Expected Outcomes:***

***Additional Information:***

**SIGNATURE PAGE**

**\*Parent signature indicated permission to circulate plan**

The following have reviewed and approved the Individual Health Care Plan and/or Emergency Action Plan included in the preceding documents:

**IHP/Action Plan developed by RN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

(print name)

**Registered Nurse signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**Parent/guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

Parent signature indicates permission to circulate the Individualized Healthcare Plan and/or the Emergency Action Plan as necessary:

Circulate Plan to: \_\_\_\_\_Teacher \_\_\_\_\_\_ TA \_\_\_\_\_\_ Transportation \_\_\_\_\_\_ Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_