
SAMPLE FORMS

This section contains sample forms to address the unique issues when serving students with health care needs. All forms can be modified and do not need to be used for each student. The forms used will be the decision of the health care planning team, based upon the student's unique needs.

Form Summary

Each student with health care needs is unique. One student might need only a health care plan; others, with complex problems, may need detailed procedures that will require extensive documentation. The following are examples of suggested forms that can be used. The school district could adapt this paperwork to meet their particular needs. ***Remember, if a student is placed in a special education program, all other required special education paperwork must be completed.***

1. INFORMATION GATHERING FORM—Completed by the school liaison. Information is gathered from parents and health care professionals.
 2. LICENSED MEDICAL PROVIDER'S ORDER/AUTHORIZATION FOR SPECIAL HEALTH CARE SERVICES TO BE PERFORMED AT SCHOOL—Gives detailed information from the licensed medical provider regarding specialized health care procedures and administration of medications. Also contains parent's signature.
 3. INDIVIDUALIZED HEALTH CARE PLAN—A detailed summary of the student's health care procedures and who will be responsible for each. Includes goals and actions.
 4. EMERGENCY PROCEDURES AND EMERGENCY PLAN—Pertinent demographics and emergency information on the student. This form should be stapled to the health care and transportation plan.
 5. TRANSPORTATION PLAN—Outlines issues and procedures for transporting the student. The bus driver, transportation aide, and substitute should have copies of this plan. The emergency procedures plan and health care plan should be attached.
 6. PERSONNEL TRAINING PLAN FOR STUDENTS WITH HEALTH CARE NEEDS—Details training of key personnel and when follow-up is necessary.
 7. DECISION GRID FOR REGISTERED PROFESSIONAL NURSES TO DELEGATE
 8. ADMINISTRATION OF MEDICATION CHECKLIST—Will assist school districts in documenting the authorized medical care given to students.
 9. DAILY LOG: MEDICATION/TREATMENT/PROCEDURE RECORD—Will assist school districts in documenting the authorized medical care given to students.
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Information Gathering Form

This form is optional and determined by the individual school district or nurse.

| | | | |
|---|------------|-----------|-----------------|
| Student | DOB | School | Grade |
| Person Completing Form | Teacher | | Date |
| DOES THE STUDENT: | YES | NO | COMMENTS |
| 1. Have a medical diagnosis of a chronic health problem (such as diabetes, tuberculosis, seizures, cystic fibrosis, asthma, muscular dystrophy, liver disease, digestive disorders, respiratory disorder, hemophilia, TBI)? | | | |
| 2. Receive medical treatments during or outside the school day (such as oxygen, gastrostomy care, special diet, tracheotomy care, suctioning, injections)? | | | |
| 3. Receive ongoing medication for conditions? | | | |
| 4. Experience frequent absences due to illness? | | | |
| 5. Experience frequent hospitalizations? | | | |
| 6. Require scheduling adjustments due to a health condition (such as rest following a seizure, limitation in physical activity, periodic break for endurance)? | | | |
| 7. Require adjustments to classroom or school facilities (such as temperature control, refrigeration/medication storage, availability of running water, modification for accessibility)? | | | |
| 8. Have other health care needs (such as special precautions in lifting, special transportation, emergency plan, special safety equipment, special techniques for positioning, feeding)? | | | |
| REVIEWED BY | | | |
| Date Received | Signature | | Title |
| | | | |

Licensed Medical Provider Order/Authorization for Health Care Services to be Performed at School

Attach Health Care Plan If Applicable

Student

Birth Date

Parent(s) Name

I. Describe Condition for which Procedure is Required

II. Describe Procedure(s) to be Performed

III. Time Schedule for Procedure

Procedure should be continued until (date) _____

IV. Precautions/Possible Adverse Reactions/Interventions

V. Describe Special Equipment Required (If Any)

VI. Describe Physical Limitations (If Any)

Authorization for Health Care Services to be Performed at School, Continued

VII. Special Dietary Requirements

VIII. Medications

| Medication(s) Prescribed | Dose | Expected Side Effects and Learning Efficiency |
|--------------------------|------|---|
|--------------------------|------|---|

IX. Parent Authorization Request for Special Health Care Procedures

I, _____, request the above health care procedures and/or medication treatment be administered to my student at school. I understand that qualified designated person(s) will be performing these health care services. I will notify the school immediately if my student's health status changes or there is a change or cancellation of the procedure/medication(s).

I understand that I am responsible for providing and bringing all medical equipment, supplies, medications (in labeled prescription bottle/container) and dietary supplements.

Parent/Guardian Signature

Date

X. Licensed Medical Provider Authorization

As the licensed medical provider for _____ (Student's Name), I verify that the procedures and treatments, as described, are necessary to be performed during the school day.

- I approve the Individualized Health Care Plan and approve of it as written.
- I approve the Individualized Health Care Plan and approve of it as modified.
- I do not approve the Individualized Health Care Plan. I have attached a substitute plan.

Licensed Medical Provider's Signature

Date

TO WHOM IT MAY CONCERN:

I hereby give my permission for the following licensed medical provider _____ and/or medical agencies _____ for exchange of confidential medical information contained in the record(s) of my student _____ date of birth _____ to _____.

Signature of Parent or Guardian

Individualized Health Care Plan

- Special Education
- 504
- School Nurse Services

I. IDENTIFYING INFORMATION

| | |
|------------|------------|
| Student | School |
| Birth Date | Teacher(s) |
| Age | Grade |

Health Care Plan for Period of _____ to _____

Licensed medical provider's order/authorization must accompany ONLY if the plan includes any medications to be dispensed or the administration of specialized procedures.

II. MEDICAL OVERVIEW

Health Condition(s) _____

Primary Health Care Provider _____

Medications _____

Possible side effects _____

Necessary health care procedures at school _____

Allergies _____

Other Important Information _____

- Transportation Plan attached.
- Training Plan attached.

Individualized Health Care Plan, Continued

III. BACKGROUND INFORMATION/NURSING ASSESSMENT

Brief Medical History

- Check if additional information is attached.
 Medical diagnosis attached.

Specific Health Care Needs

- Check if additional information is attached.

Developmental Abilities (Related to Health Concerns)

- Check if additional information is attached.

IV. HEALTH CARE ACTION PLAN

- Attached licensed medical provider's order and other standards for care.

Procedures and Interventions (student specific)

| Procedures | Administered by | Equipment | Maintained by | Auth/trained by |
|------------|-----------------|-----------|---------------|-----------------|
| | | | | |

Medications taken during school hours:

- Check if additional information is attached.

Diet

- Check if additional information is attached

Individualized Health Care Plan, Continued

Safety Measures

Check if transportation plan is attached.

| Equipment (list necessary equipment/supplies) | Provided by Parent | Provided by School |
|---|--------------------|--------------------|
| 1. | | |
| 2. | | |

V. PARENT AUTHORIZATION FOR SPECIAL HEALTH SERVICES

We (I), the undersigned who are the parents/guardians of _____
(Student) (Birth Date)
 request and approve this Individualized Health Care and if needed, Emergency Procedures Plan.
 We (I) will notify the school immediately if the health care status of our (my) child changes.

_____ Signature _____ Date

Parent(s) _____

Student, if appropriate _____

Administrator or Designee _____

Teacher (s) _____

Family Licensed Medical Provider, if appropriate _____

School Nurse _____ Other _____

VI. INDIVIDUALIZED HEALTH CARE PLAN REVIEW

Next review date of Individual Health Care Plan _____

School Nurse Responsible _____

Name: _____

Date: _____

School Nurse: _____

Individualized Health Care Plan

| Date | Health Need/ Nursing Diagnosis | Goals | Action/Intervention | Evaluation |
|------|-----------------------------------|-------|---------------------|------------|
| | | | | |

Emergency Procedures Plan

Student's
Picture

Student _____ Birth Date _____

Address _____ Telephone _____

Parent _____ Work _____ Home _____

Parent _____ Work _____ Home _____

Other Contact _____ Telephone _____

Summary of medical information (e.g., medications, allergies, precautions, etc.)

Emergency Numbers (if applicable)

Preferred Hospital _____ Telephone _____

Primary Licensed Medical Provider _____ Telephone _____

Home Care Co. _____ Telephone _____

Medical Supplier Responsible for Maintaining Equipment _____

Specialists (if applicable)

_____ Telephone _____

_____ Telephone _____

Make in Triplicate:

1. Transportation (attach to Transportation Plan)
2. Student File
3. Available in Classroom

Emergency Plan Procedures (Continued)

If an emergency occurs

1. Stay with student or designate another adult to do so.
2. If the emergency is life-threatening, immediately call 9-1-1.
 - a. Tell who you are.
 - b. State where you are.
 - c. Explain the problem.
3. Call or designate someone to call the principal and/or health care provider.
4. The following staff members are trained to deal with an emergency and to initiate the emergency plan:

| IF YOU SEE THIS | DO THIS |
|-----------------|---------|
| | |

If there is a natural disaster, e.g., earthquake, flood, etc., you must have emergency plan procedures in place (Ex: 3-4 days' supply of medications, plans for equipment failure or power failure, etc.)

Transportation Plan

Student's Picture

Bus Driver: _____ Bus # _____

Student: _____

| | | | |
|---|--|-------------------------|-------------------------|
| Address | | Home Telephone | |
| School | | Grade | |
| Parent/Guardian Name | | Work Telephone (Father) | Work Telephone (Mother) |
| Receives Medication Yes <input type="checkbox"/> No <input type="checkbox"/> | | Possible Side Effects | |
| Method of Mobility | | Method of Communication | |
| Student Care Provider | | Emergency Drop-off Site | |
| Address | | Telephone | |

I. Transportation Staff Training

Describe Training:

Date training completed:

II. Adaptations/Accommodations Required Yes No

| | | |
|--|---|---|
| <input type="checkbox"/> Bus Lift <input type="checkbox"/> Seat Belt <input type="checkbox"/> Wheelchair Tie-Downs | <input type="checkbox"/> Chest Harness <input type="checkbox"/> Booster Seat <input type="checkbox"/> Other _____ | Walks to and from bus Yes <input type="checkbox"/> No <input type="checkbox"/> Walks up and down stairs Yes <input type="checkbox"/> No <input type="checkbox"/> |
|--|---|---|

| |
|--|
| |
|--|

Transportation Plan (Continued)

Identify equipment that must be transported on the bus and method of securing (including oxygen, life-sustaining equipment, wheelchair equipment, communication device).

III. Positioning or Handling Requirements Yes No

IV. Behavior Considerations Yes No

Describe

V. Student Specific Emergency Procedure

| IF YOU SEE THIS | DO THIS |
|-----------------|---------|
| | |
| | |
| | |
| | |
| | |
| | |

VI. Student Specific Emergency Procedure

Attach a copy of student's Emergency Procedures Plan, as appropriate.

School Personnel Training Plan for a Student with Health Care Needs

| | | | | |
|-------------------------------------|-----|-------------------|-------|------|
| Student | DOB | School | Grade | Date |
| Staff to be trained | | Name of training | | |
| Instructor | | | | |
| Date of training | | | | |
| Describe training to be provided | | | | |
| Training Completed | | | | |
| Staff trained | | Training Provided | | |
| Instructor Signature | | | | |
| Date of training | | | | |
| Describe training provided | | | | |
| Recommendation for follow-up review | | | | |

Decision Grid for Registered Professional Nurses to Delegate*

| Task & Specific Patient Combination | Potential for Harm | Complexity of Task | Problem Solving/ Innovation Needed | Unpredictability of Outcome | Level of Interaction Required w/Client | TOTAL |
|-------------------------------------|--------------------|--------------------|------------------------------------|-----------------------------|--|-------|
| | | | | | | |
| | | | | | | |

Instructions: This grid can be used to evaluate activities considered for delegation to non-licensed assistive personnel. For the task at hand, consider both the task and the patient involved. Score each risk factor according to this scale (0=none, 1=low, 2=moderate, 3=high). There is a total of a maximum of 15 points. The higher the score, the less likely it is that the registered professional nurse should delegate the task/activity.

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Administration of Medication Checklist

The following checklist is to help school districts determine if they are consistent with state law regarding the administration of medication.

| YES | NO | The School |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has designated employees who may administer medication. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Has a policy for proper identification and safekeeping of medication. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Has provided training for designated employees. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Has a procedure for the maintenance of records for administration. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Has current parent or guardian written and signed permission for medication to be administered at school. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Has a copy of the student's health care provider's signed statement describing the method, amount, and time schedule for administration. |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Has a copy of the student's health care provider's statement that administration for medication by school employees during the school day is necessary. |

Daily Log: Medication/Treatment/Procedure Record

I. Identifying Information

| | | | |
|---------------------------|-----|---|-------|
| Student | DOB | School | Grade |
| Teacher | | Name of Individual Administering Medication/Treatment | |
| Licensed Medical Provider | | Phone | |

II. Medications

| Medication/Treatment | Time Frequency | Dosage | How Given | Expected Effects on Learning and Special Considerations |
|----------------------|----------------|--------|-----------|---|
| 1) | | | | |
| 2) | | | | |
| 3) | | | | |
| 4) | | | | |
| 5) | | | | |

III. Daily Log: Medication/Treatment/Procedure

| Date/Time | | Medication/Treatment/Procedure | Administered By |
|-----------|------|--------------------------------|-----------------|
| Date | Time | | Initials |
| | | | |
| | | | |
| | | | |

