Nursing Services Individual Health Plan (IHP)/ Nursing Services Individual Treatment Plan (ITP)

To be updated annually or sooner as needed

Student Name (*last, first*):	**DOB**:	**Gender:**	**Grade:**		**School:**

Medicaid ID-

Current ICD CODE

Health Care Provider:

Primary Insurance:

Medical Diagnosis on File:

Initial Assessment Summary:

Allergies:

Nursing Diagnosis	**Goals**	**Interventions**	**Person Responsible**
	1.		
	2.		
	3.		

Expected Student Outcome	**Expected Student Outcome**	**Expected Student Outcome**	**Expected Student Outcome**

Plan of Care Date	**Additional Assessment Information**	**Goal # Addressed**	**Medication, Treatment or Procedure**	**Dose**	**Frequency**	**Discontinue**	**Nurse Signature**

RN: _____ _____ _____ _____

Rev: 2020

Print Name *Signature* *Initials* *Date Signed*

**If all of the medical orders will be followed by the school as written and the IHP/ITP is consistent with the medical orders, the signature of the Health Care Practitioner and the student's parent/guardian on the IHP/ITP will not be required. However, if the IHP/ITP is not consistent with medical orders, the IHP/ITP Provider Response Form and the Parental Response Form will need to be signed.*
**EAP will be developed, if applicable.*

IHP/ITP Approvals (if applicable)

This IHP/ITP is for_____ was prepared by the following nurse:

RN's signature:_____ Date:_____

RN's name (*print/type*):_____ RN's initials:_____

Additional school staff signature (if applicable):_____

Review plan: □ beginning of next school year □ upon parent/health care practitioner/school request □ other: _____

IHP/ITP Approvals (if not already obtained through the medical order)

Note: By signing this document, the parent/guardian and/or the student authorize sharing this information with school personnel who have a legitimate need for knowledge of the information.

Parent/guardian: I agree with this plan of care for my child while he or she is at school or attending school-sponsored functions. I agree to let the school know of changes in my child's health condition or treatment and changes to the contact information on page 1 of this individual health care plan. Sign name: _ Print name: _____ Date: _____	**Health care practitioner:** I agree with this plan of care while at school or attending school-sponsored functions. Sign name: _____ Print name: _____ Date: _____
Student (if appropriate): I agree with this plan of care for me while I am at school or school-sponsored functions. Sign name: _____ Print name: _____ Date: _____	**Health care practitioner:** I agree with this plan of care while at school or attending school-sponsored functions. Sign name: _____ Print name: _____ Date: _____