

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

To be updated annually or sooner as needed

<b>Student Name</b> <i>(last, first):</i>	<b>DOB:</b>	<b>Gender:</b>	<b>Grade:</b>		<b>School:</b>
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**Medicaid  
ID-**

**Current ICD CODE**

**Health Care Provider:**

**Primary**

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**Insurance:**

**Medical Diagnosis on File:**

<b>Initial Assessment Summary:</b>	<b>Allergies:</b>

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: \_\_\_\_\_

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: \_\_\_\_\_

**Student's last name and first initial:** \_\_\_\_\_ **RN's initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **(page** \_\_\_\_\_