INDIVIDUAL HEALTH PLAN

BELLEVUE SCHOOL DISTRICT 2022-2023

Name:		DOB:		Date:	
School:		Grade/Teacher:			
HEALTH CONCERN –					

HEALTH ACTION PLAN

Watch for symptoms of low cortisol and CALL Parents if you notice:

- headache
- loss of appetite
- weakness, lethargy, tired
- pain in back, abdomen, legs
- vomiting, diarrhea
- increased urination
- Confused, dizzy
- Cold, clammy, skin
- Fast breathing

If injured, stressed, or fever >99 degrees:

1. Have student rest, facilitate relaxation and calmness.
2. Offer water for sipping. Encourage student to remove jacket/layers off for cooling.
3. Call parent if interventions are not effective and as needed for elevated temperature >99 degrees
4. Follow medication orders if indicated.

EMERGENCY CARE PLAN

If SEVERE stress (such as broken bones, head trauma, auto accident, seizure, unconsciousness,
OR
has symptoms of acute adrenal insufficiency: Confusion, extreme tiredness or weakness, lower body temperature, severe pain in lower back, dehydration, cold, pale, clammy skin, fast pulse, dizziness, or fast breathing
CALL 911 then call Parents.

MEDICATION ORDERS *Can be filled out by licensed health care provider; MD, DO, ND, DMD, DC, PA, ARNP, CNM.*
IHP can be filled out by School Nurse based on BSD "Authorization for Medication to be Taken at School" form

Medication: **(dose)** via:

(Please circle **route**) Oral / Inhaler / Topical / Injection- Specify IM or Subcutaneous / Eye drops / Ear drops / Other:

ever (**frequency**) for

(**indicate when to use**)

SELF CARRY, Health Care Provider please check one ***(STAFF HAS BEEN TRAINED TO ASSIST WITH MEDICATION ADMINISTRATION)***

☐ NO, student MAY NOT self carry.

☐ YES student may SELF CARRY/ADMINISTER. *Provider/student/parent/guardian understands the responsibility of self-carrying medication at school and recognizes that the school **will not** be able to track compliance. As a parent/guardian of the student, I agree to hold harmless and indemnify the school and Bellevue School District's officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by their student.*

Licensed Health Care Provider's signature:	**Date:**		**Phone:**	
_____	**School year:**		**Fax:**	
Signature authorizes medication for length of school year				

I accept this Individual Health Plan. *My signature gives permission for exchange of information between the School Nurse and the Health Care Provider regarding this medication order.*

Parent/Guardian/Student (age 18) signature:	**Date:**	
_____		

Family Responsibility:

- I will keep track of expiration dates for the medication(s)
- I will furnish medication(s) in original container and pick up medication(s) from the school

If the student *DOES NOT* self-carry, I request an authorized/trained person(s) at **school assist my student** in taking the medicine(s) described below.

If the student has permission to *SELF-CARRY and/or SELF-ADMINISTER THIS MEDICATION* I/my student understand the responsibility of self-carrying medication at school and recognizes the school will not track compliance, expiration, or amount. I/my student agrees to hold harmless and indemnify the school and Bellevue School District's officers, employees, and agents against all claims, judgments, or liabilities arising out of the self-administration and carrying of medication by myself/my student.

Parent/Guardian/Student (age 18) signature: _____	**Date:**		**Phone:**	

INDIVIDUAL CONSIDERATIONS

Parent: If student attends extended day/childcare, clubs before & after school, evening and summer activities, parent will notify the program director of their child's medication and health care needs.
Classroom: Teacher to inform substitute teachers of the student's Individual Health Plan
Field Trip Procedures: Medication and IHP will accompany student during any off-campus activity
Transportation: Bus-Transportation will be informed of the student's Individual Health Plan
Other: RN will notify teachers, specialists, recess staff, and other staff of student's IHP

School Nurse:	, RN	**Email:**	@bsd405.org	**Phone:**	425-456-
				Fax:	425-456-