_____ INDIVIDUAL HEALTH PLAN

BELLEVUE SCHOOL DISTRICT 2020-2021

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

HEALTH ACTION PLAN

SELF CARRY, Health Care Provider please choose one:

☐ NO, student MAY NOT self carry.

☐ YES student may SELF CARRY. Checking "YES" indicates that the student may SELF-CARRY.

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: _____ *Signature authorizes medication for length of school year*	**Date:**	_____	**Phone:**	_____
	School year:	_____	**Fax:**	_____
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 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:		**Email:**	@bsd405.org	**Phone:**	425-456-
				Fax:	425-456-

Updated 4/2020