

INDIVIDUAL HEALTH PLAN

BELLEVUE SCHOOL DISTRICT 2022-2023

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

MEDICATION *Can be filled out by licensed health care provider; MD, DO, ND, DMD, DC, PA, ARNP, CNM.*

ORDERS *IHP can be filled out by School Nurse based on BSD "Authorization for Medication to be Taken at School" form*

EMERGENCY CARE PLAN: ADMINISTER MEDICATION AS DIRECTED

MEDICATION, Health Care Provider, please complete:

- **MEDICATION NAME:**
- **MEDICATION DOSE:**
- **MEDICATION ROUTE:**
- **INDICATION FOR 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:	
<small>Signature authorizes medication for length of school year</small>	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/Student (age 18) signature:	Date:
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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:	
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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

INDIVIDUAL CONSIDERATIONS (Contd)

Other: RN will notify teachers, specialists, recess staff, and other staff of student’s IHP

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