HEMOPHILIA INDIVIDUAL HEALTH PLAN

BELLEVUE SCHOOL DISTRICT 2022-2023

Name:		DOB:		Date:	
School:		Grade/Teacher:			
HEALTH CONCERN – **:** When blood cannot clot properly, and excessive bleeding can occur (internal and external) after an injury or damage.					

SIGNS & SYMPTOMS OF BLEEDING:

- Obvious external bleeding.
- Obvious signs of discomfort or pain – swelling doesn't always occur.
- Area of pain which is warm to the touch. Muscles in effected area may be tight and tender to touch.
- Decreased range of motion, stiffness, unable to bend, or restricted use. Arm/leg in abnormal position.
- Student may report a tingling or other sensation like numbness.

EMERGENCY CARE PLAN

- Minor injuries such as small cuts, abrasion, nosebleeds and mouth bleeds are usually not serious but must be attended to promptly and monitored to ensure bleeding has stopped.
- Use ***lots of ICE*** early on for any injury
- Use RICE: **Rest, Ice, Compression & Elevation** for bumps, bruises, or muscle soreness.
- Call parents whenever STUDENT is injured at school – bumped, cut or bruised.
- Though a bump may seem minor, the internal bleed can show up later. **ICE all bumps**.
- Ask STUDENT "when was your last injection*?" when he is injured. ***(factor 8 Advate given at home)***
- For periodic mouth or oral bleeding ***Amicar liquid*** medication is on hand at school
- For breakthrough bleeding or injury, treat with injectable medication ***Advate***. This can be administered by RN, STUDENT, parent or emergency medical responders

If unable to reach parent, call Bloodworks N.W. 206-292-6507 and ask to speak with a hemophilia nurse specialist

CALL 911:

- For head injury with loss of consciousness
- For breathing trouble due to neck trauma. Internal bleeds to neck area can be serious.
- If a fracture is suspected
- If parent cannot be reached and there has been a blow to the head, neck or abdomen

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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

EMERGENCY CARE PLAN: ADMINISTER MEDICATION AS DIRECTED

<u>MEDICATION, Health Care Provider, please complete:</u>

- **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: _____ ***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/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, supplies, 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-

Updated 4/2022