Linda McCulloch, Superintendent
Office of Public Instruction
PO Box 202501
Helena, Montana 59620-2501
www.opi.state.mt.us

Individualized Health Care Plan

I. IDENTIFYING INFORMATION

Student's Name	School
Birthdate	Teacher
Age	Grade

CONTACTS

PARENTS

Mother's Name

Mother's Address

Mother's Home Telephone Work Telephone Emerg. Telephone

Father's Name

Father's Address

Father's Home Telephone Work Telephone Emerg. Telephone

PHYSICIAN

Physician Telephone

Physician Address

HOSPITAL

Hospital Emergency Room Telephone

Hospital Address

Ambulance Service Telephone

SCHOOL

School Nurse Telephone

II. MEDICAL OVERVIEW

Medical Condition Any Known Allergies

Medications

Possible Side Effects

Necessary Health Care Procedures at School

Health Care Plan for Period to

III. OTHER IMPORTANT INFORMATION

IV. BACKGROUND INFORMATION/NURSING ASSESSMENT

Brief Medical History

☐ Check if additional information is attached.

Specific Health Care Needs

☐ Check if additional information is attached.

Social/Emotional Concerns

☐ Check if additional information is attached.

Academic Achievement

☐ Check if additional information is attached.

V. HEALTH CARE ACTION PLAN

☐ **Attach physician's order and other standards for care.**

Procedures and Interventions (student specific)

Procedure	Administered by	Equipment	Maintained by	Auth/trained by
1.				
2.				
3.				

V. HEALTH CARE ACTION PLAN (cont.)

Medications

☐ Attach medication form and administration log.

Diet

☐ Check if additional information is attached.

Transportation

☐ Check if additional information is attached.

Classroom School Modifications (including adapted PE)

☐ Check if additional information is attached.

Equipment—List necessary equipment/supplies	Provided by Parent	Provided by District
1.		
2.		
3.		
4.		

☐ None Required

Safety Measures

☐ Check if additional information is attached.

Emergency Plan ☐ Attached Transportation Plan ☐ Attached Training Plan ☐ Attached

Substitute/Backup Staff (when primary staff not available)

Possible Problems to be Expected

Training

VI. HEALTH CARE PLAN REVIEW

Next review date of Health Care Plan _____

VII. DOCUMENTATION OF PARTICIPATION

We have participated in the development of the Health Care Plan and agree with its contents.

Signature Date

_____ Administrator or Designee

_____ Teacher

_____ Nurse

_____

_____

VIII. PARENT AUTHORIZATION FOR SPECIAL HEALTH SERVICES

We (I), the undersigned who are the parents/guardians of _____ (Student Name), _____ (Birthdate) request and approve the attached Individualized Health Care Plan. We (I) understand that a qualified designated person(s) will be performing the health care service. It is our understanding that in performing this service, the designated person(s) will be using a standardized procedure which has been approved by the student's Health Care Team and Physician.

We (I) will notify the school immediately if the health status of _____ (Student Name) changes, we change physicians, or there is a change or cancellation of the procedure.

We (I) agree to provide the following, if any: medical equipment and supplies, medication, dietary supplements.

_____
Parent Signature

Date_____

_____
Parent Signature

Date_____