Individualized Health Care Plan(IHP)/Emergency Action Plan(EAP) for Student with Cystic Fibrosis

Name_____Date of Birth_____

Parent/Guardian_____

Phone (h)_____ (w)_____ (c) _____

Physician_____Phone_____
Fax_____

Specifics of Management:
Current Medications:

_____
_____
_____

Please note any ACTIVITY Limitations/Restrictions: _____
_____

- ☐ May participate in physical education class if oxygen saturation over_____
- ☐ May participate in outdoor recess if oxygen saturation over_____ and outdoor temperature over _____ and under_____.

Nutrition:

- ☐ Supplement ordered_____
  Time to be given at school_____
- ☐ Use G tube if a student doesn't drink supplement within _____minutes.
- ☐ Snacks needed between meals _____
- ☐ Monitor growth by recording height/weight every _____

Fever:
Notify parent/guardian if temperature is over _____.

Pulse Oximeter/Nebulizer Treatments:
Student's Normal Baseline oxygen saturation is _____%

Please indicate when student should have oxygen saturation checked with a pulse oximeter. Check all that apply. If PRN please provide SPECIFIC guidelines:

- ☐ Before breathing treatment
- ☐ After breathing treatment
- ☐ Before activity
- ☐ After activity
- ☐ Upon arrival/return to school
- ☐ When signs of respiratory distress--specific individual symptoms:
  _____
- ☐ PRN- please provide SPECIFIC guidelines: _____
  _____

Recommended Interventions when student is showing signs of respiratory distress (pale, short of breath, persistent cough, pulse oximeter below baseline, lethargic)
Check all that apply.

- ☐ Notify parent/guardian.
- ☐ Encourage student to assume a position of comfort.
- ☐ Encourage slow, deep, even breaths.
- ☐ Administer Nebulizer:_____
- ☐ Rest in Nurse's office for _____

Emergency Plan:
If oxygen saturations remain between _____% and _____% after interventions listed, call parent/guardian.

If oxygen saturations remain below_____% after interventions listed, CALL 911

Additional Health Care Provider or Parent Comments:
_____
_____
_____

Physician Consent for Cystic Fibrosis IHP

I have reviewed and approved this management plan and included any recommended modifications. This consent is for a maximum of one year. If changes in procedure are indicated, I will provide written orders accordingly.

Physician/Health Care Provider Signature **Date**

Parent Consent for Cystic Fibrosis IHP

I, as parent/guardian, concur with the above management plan, and will provide the necessary supplies and equipment, notify the school nurse if there is any change in our child's health status or doctor's orders, and authorize the school nurse to contact the physician when necessary.

Parent/Guardian Signature **Date**