

Individualized HealthCare Plan(IHP)/Emergency Action Plan(EAP) for Student with Multiple Medical Needs

Student Name _____ **DOB:** _____

Parent/Guardian _____

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

Physician _____ **Phone** _____

Fax _____

Specifics of Management:

Diagnoses:

Please note any ACTIVITY Limitations/Restrictions/Assistive Devices:

Nutrition:

- Give per G-tube
- Give orally
- NPO
- or other specific oral feeding instructions: _____

Product to be used for tube feeding _____

Amount: _____ Approximate Time _____

Give by gravity _____ or bolus _____

Water flush amount before feeding _____ after feeding _____ or NO FLUSH _____

Medications: _____

- Give by G-tube
- Give Orally.

Other specific directions for medication administration

Seizures:

Please describe typical seizure behavior:

Date of last seizure:

- VNS device--date VNS was last checked by physician_____
- PRN medications for seizure activity_____

Describe any interventions needed for seizure activity (to go home, call parents, call 911, if/when may return to classroom)

Toileting schedule/concerns:

Catheterization: _____

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Colostomy: _____

Colostomy system in use since _____

Nurse/Student may change appliance as needed (Please circle who changes colostomy)

Specific Instructions for Colostomy care: _____

Additional Health Care Provider or Parent Comments:

Physician Consent for Student with Multiple Medical Needs

I have reviewed and approved this management plan and have 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.

Nurse may replace G-button with proper training.

Training on G-button replacement will be provided by: _____

Other Comments:

Physician/Health Care Provider Signature

Date

Parent Consent for Student with Multiple Medical Needs

I, as parent/guardian, concur with the above management plan, and will provide the necessary supplies, medications and equipment, will 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