Specialized Health Care Needs IHP Information

Student: _____ D.O.B _____ Grade: _____

Parent/Legal Guardian Name: _____

Potential health fragility and complications secondary to medical diagnosis and treatment regimens in the school setting.
Goal: Student will have medical needs met with minimal disruption to the educational process. Student will have a safe medical plan for school, communicated to key personnel.

Diagnosis: _____

Specific Health Needs

Respiratory Needs ☐Nebulizer daily/as needed ☐Oxygen continuous/as needed ☐ Tracheostomy/suctioning ☐Vent ☐ Ambu bag ☐Other
Specifics:_____

Gastrointestinal/Nutritional Needs ☐oral feeding ☐prompt to swallow/chew ☐ tube feeding type_____ ☐other _____
Specifics:_____

Mobility Needs: ☐ walks without help ☐stand with assistance ☐ wheelchair ☐uses a walker ☐braces/splints ☐helmet ☐Other _____
Specifics:_____

Toileting Needs ☐Diaper/pull ups ☐Urethral catheter ☐Urostomy ☐ Colostomy/ileostomy ☐ other_____
Specifics: _____

Communication/Sensory Needs: ☐Verbal ☐Nonverbal ☐Signs ☐ Hearing Aids ☐Glasses ☐Other _____
Specifics:_____

Additional things we should know about working with this student: _____
_____

Outside Activity/Field Trips. ***The following medications/ equipment should accompany my child when participating in outside activity and field trips.*** **Include DIRECTIONS**

I am aware that performance of special procedures may be done by non-medical staff trained by the school nurse with guidance from parent or physician. I agree that this information (plan) may be shared with the appropriate staff, who works with the student, on a need to know basis. I hereby release Northern Wells Community Schools and any of its agents, employees, administrators from any liability for any injury or harm which is suffered by my child because of our district's agreement to honor the above request. I agree to allow the school nurse to contact my physician about my child's treatment plan for school**.** I agree to keep the school nurse updated in writing about my child's health and contact the school nurse in writing if any changes are made in the plan.

Parent Signature: _____ Date: _____

School Nurse: _____ Date: _____

Physician Signature: _____ Date: _____