**INDIVIDUALIZED HEALTH CARE PLAN CHECK LIST FOR THE SCHOOL NURSE**

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| STUDENT: |  | | | D.O.B.: |  |
| STUDENT #: |  | SCHOOL: |  | DATE: |  |

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| 1. Enter completion date and initial each step listed below.  2. File completed checklist in the student’s health file. |

Date and Initial

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 1. Health Care Plan developed with |  | and |  |
|  |  | Parent or guardian |  | Area nurse consultant |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 2. Physician signature needed: |  | is not needed: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 3. Send home original Health Care Plan and memo from nurse consultant: | | | | | | |
|  | with student: |  | by mail: |  | by email: |  | for parent signature. |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | 4. School staff information and copy of Health Care Plan to the following: | | | | | |
|  | Clinic aide |  | Secretaries |  | Classroom teacher |  |
|  | EA |  | P.E. |  | Art |  |
|  | Music |  | Cafeteria |  | Transportation |  |
|  | Others: |  | | | | |
|  |  | List Names | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
|  | 5. Copies of signed plan in |  | Clinic Health Care Plan Book |
|  |  |  | Substitute Folder |
|  |  |  | With student information/emergency page |

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|  | 6. Original plan with signatures in health file. |

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|  | 7. Classroom presentation requested: |  | No |  | Yes | Who requested: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | 8. Inservice: |  | No |  | Yes | Who requested: |  |

|  |  |  |  |  |  |
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|  | 9. Training/delegation needed: |  | No |  | Yes |

|  |  |  |  |  |  |  |
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|  | Procedure: #1 |  | | | | |
|  | Staff: Name: |  | Position: |  | Date: |  |
|  | Staff: Name: |  | Position: |  | Date: |  |
|  | Staff: Name: |  | Position: |  | Date: |  |
|  | Procedure: #2 |  | | | | |
|  | Staff: Name: |  | Position: |  | Date: |  |
|  | Staff: Name: |  | Position: |  | Date: |  |
|  | Staff: Name: |  | Position: |  | Date: |  |
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| ALL HEALTH CARE PLANS ARE CONFIDENTIAL  (Information to be shared on a need to know basis only!) |