LITTLE ROCK SCHOOL DISTRICT

HEALTH SERVICES

INDIVIDUAL HEALTH CARE PLAN

Act 1565 (1999) amends Annotated Arkansas Code 6-18-1005 to require Individual Healthcare Plans for students with special health care needs in schools. **(This information is CONFIDENTIAL.)**

Student's Name _____ Date of Birth _____ Grade _____

School _____ Allergies _____

Student's Diagnosis _____

Brief history of medical condition _____

PROCEDURES AND INTERVENTIONS (TO BE COMPLETED BY PHYSICIAN OR CLINIC NURSE)

1. Does the student require assistance to attend school? _____ If YES, documentation in items 2-10 should support this requirement.

2. Health care treatments, medications, or procedures (i.e. blood sugars, caths, etc.) at school:
   _____
   _____

3. Health care treatments, medications, or procedures at home: _____
   _____

4. Potential side-effects of medication(s) or treatment(s): _____

5. Transportation (bus, parents, etc.): _____

6. Suggested environmental modifications (seating in front of room, avoidance of specific allergens, etc.):
   _____

7. List necessary equipment and supplies and person(s) responsible for providing these items:
_____
_____

8. Safety Measures: _____

9. Dietary requirements: (Certification of disability form must be completed for school to accommodate.): _____

10. Activity Limitations:_____

PLEASE ATTACH A COPY OF STUDENT'S MOST RECENT PHYSICAL EXAMINATION

Physician's Signature _____ Date Signed _____

Emergency Plan ( ) Attached ( ) Check if additional information is attached.

LRSD IHP

Student's Name _____

HEALTHCARE PLAN
(TO BE COMPLETED BY SCHOOL NURSE AND SCHOOL TEAM)

Health Care Procedures Check ( ): Health Care Procedures should be attached.

Is backup staff available and trained if primary staff not available _____ Yes _____ No

Possible Problems to Anticipate and Interventions

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Training (Type)	Date Attended	Total Hours	Staff Attended

DOCUMENTATION OF PARTICIPATION

We have participated in the development of the Healthcare Plan and agree with its contents. Parent/guardian agrees to notify the school of the following changes or cancellations occur: the health status, physician (s), the procedure(s).

Signatures **Date**

_____ Parent/Guardian

_____ Nurse

_____ Principal/Designee

(Revised 3/07-ADE)
(Revised 8/08-LRSD)