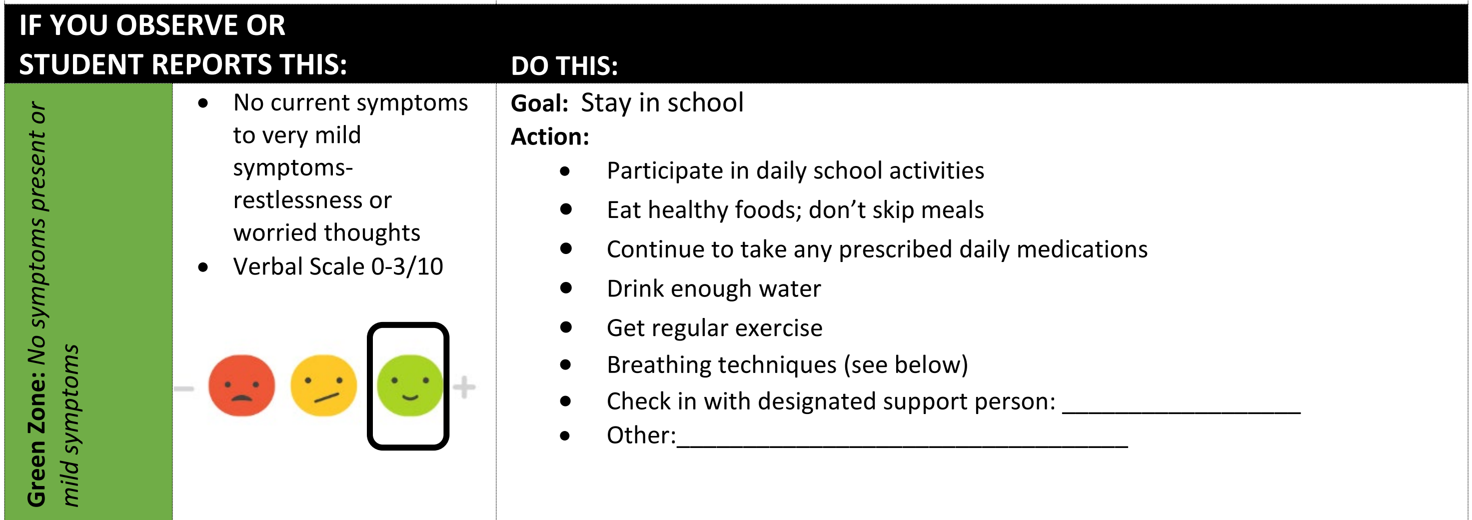
Confidential Individualized Healthcare Plan

[Nurse Name and Credentials]

Student Name: **Birth Date** **School** **Grade**

Parent/Guardian:	**Name & Phone #**
Parent/Guardian:	**Name & Phone #**
Healthcare Provider	**Primary Care Provider & Phone #**
Healthcare Provider	**Specialist & Phone # Mental Health Provider:**
Preferred Hospital:	**Preferred Hospital**
Emergency Contact:	**Name, Relationship & Phone #** *(other than parent/legal guardian)*
Contributing Health factors:	Anxiety Do they have ☐504 ☐IEP ☐RTI
PERTINENT HEALTH HISTORY	Anxiety
ALLERGIES:	
RESTRICTIONS:	
CURRENT MEDICATIONS:	**DAILY MEDICATIONS AT HOME** [Example: *Lexapro 15mg, every morning.* *Clonidine 0.1 mg, at bedtime (as needed).* *Clonidine 0.05mg, before school (as needed). If taken at bedtime, then will not give in morning because still drowsy*]



IF YOU OBSERVE OR STUDENT REPORTS THIS:		**DO THIS:**
Green Zone: *No symptoms present or mild symptoms*	• No current symptoms to very mild symptoms- restlessness or worried thoughts • Verbal Scale 0-3/10	**Goal:** Stay in school **Action:** • Participate in daily school activities • Eat healthy foods; don't skip meals • Continue to take any prescribed daily medications • Drink enough water • Get regular exercise • Breathing techniques (see below) • Check in with designated support person: ___________________ • Other:____________________________________

Revised and adopted by CHCO School Health Program 2020 from CDE http://www.cde.state.co.us/HealthAndWellness/SNH_HealthIssues.htm.

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Student Name:	**Birth Date**	**School**	**Grade**

Yellow Zone: *Student is feeling anxious and is not sure if they can make it through the school day*	• Symptoms may include avoiding activities, irritability/anger, difficulty concentrating, heart pounding, having trouble breathing, or feeling dizzy, shaky, or sweaty [*Ideally, identify symptoms specific to the student*] • Verbal Scale 4-6/10	**Goal:** Stay in School **Action: [***Identify actions that are known to be helpful for the specific student, including relevant actions in IEP or 504 or RTI***]** **Start with non-pharmacologic therapies that could include:** (non-chronological order but can be used in order) ○ Taking a break for ____ mins. ○ Breathing techniques (square breathing, see below; younger students can blow bubbles or feathers) ○ 5-4-3-2-1 technique (see below) ○ Listen to soothing music ○ Get a cold drink of water or using ice/ice pack or use cold compress ○ Squeeze something (play dough, clay, silly putty, your fists, a stress ball) ○ Name animals alphabetically (alligator, bear, cow, dog, etc…) ○ Give yourself a hug- squeeze tight! ○ Eat a sour candy ○ Imagine your favorite place, think of your favorite things, or remember the words to a song you love ○ Other:___________________________________ **If student is still in the yellow zone after using non-pharmacologic therapies [**if possible, include a specific amount of time to try non-pharmacologic therapies prior to giving medication, i.e. 10 minutes**], give medication** ○ Student can take [*medication*] [*dose*] by mouth [*frequency*] as needed (maximum of [*#*] doses during the school day). ○ [*Add any special medication considerations or instructions here. Example: If student requests clonidine before she has been at school for 3 hours, call parents to ask if she took a dose at home before coming to school. Call parents to update if student takes clonidine during the school day. Hypotension and syncope are safety risks of taking clonidine. Please have student lay down in the health office if she experiences lightheadedness or dizziness after taking clonidine and call parents.*]

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Student Name:	**Birth Date**	**School**	**Grade**

Zone	Symptoms	Goal and Action
Red Zone: Student's anxiety is at a level where they feel like they can not stay at school for the day.	• Student is not responding to actions in Green and Yellow Zones • Symptoms may include irritability/anger, difficulty concentrating, heart pounding, having trouble breathing, or feeling dizzy, shaky, or sweaty [*Ideally, identify symptoms specific to the student*] • Verbal Scale 7-10/10	**Goal: Stay in School** **Action:** ○ Student can take [*medication*] [*dose*] by mouth [*frequency*] as needed (maximum of [#] doses during the school day). ○ Inform parents of use of PRN medication including time, dose and brief description of circumstance (many can have side effects if parents aren't aware and administer another dose at home too soon) ○ If student does not improve in ____mins after interventions, call parents to discuss next steps. ○ [*Add any special medication considerations or instructions here. Example: If student requests clonidine before she has been at school for 3 hours, call parents to ask if she took a dose at home before coming to school. Call parents to update if student takes clonidine during the school day. Hypotension and syncope are safety risks of taking clonidine. Please have student lay down in the health office if she experiences lightheadedness or dizziness after taking clonidine and call parents.*] **Call 911 if you see the following:** ○ Active self-harm or harm to others ○ Parents are unresponsive to phone call requests for the student to be picked up and their anxiety continues to be 7-10/10 ___ mins after interventions.

EMERGENCY ACTION PLAN	Shelter in place – Per existing school plan Evacuation plan – Per existing school plan

This service is medically necessary through the following dates, not to exceed one year.
Start Date: **End Date***:* End of school year

TO THE PARENT/GUARDIAN: If Student's Name ("Student") experiences a change in their health condition (such as a change in medication or a hospitalization) please contact the School Nurse Consultant so that this Health Care Plan can be revised, if needed. Parent/guardian signature indicates permission to contact the student's health care provider(s) listed above, as needed. I understand that the School Nurse Consultant may delegate this health care plan to unlicensed school personnel. I give permission for school personnel to carry out this care plan for the Student. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure the Student's safety and well-being while at school or during school related activities.

Parent/Guardian Date

School Nurse

Date

Health Care Provider

Date

Administrator

Date

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Staff trained to care for student:

1. ________________________________
2. ________________________________
3. ________________________________
4. ________________________________
5. ________________________________

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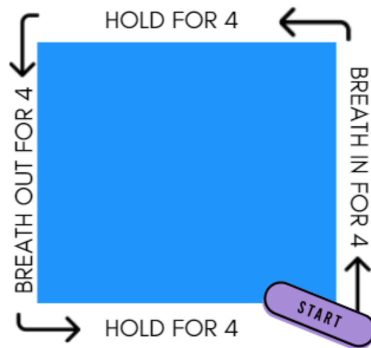
SQUARE BREATHING

- Start at the bottom right of the square
- Breathe in for four counts as you trace the first side of the square
- Hold your breath for four counts as you trace the second side of the square
- Breathe out for four counts as you trace the third side of the square
- Hold your breath for four counts as you trace the final side of the square
- You just completed one deep breath!



GROUNDING USING YOUR 5-SENSES

What are / *Ideas*

5 THINGS YOU CAN SEE

Sky
Trees
Birds
People
Wall Fixtures

4 THINGS YOU CAN TOUCH

Feet on the Floor
Pencil in Hand
Texture of Clothes

3 THINGS YOU CAN HEAR

White Noise
Cars Passing
Clock Ticking
People Talking

2 THINGS YOU CAN SMELL

Food
Grass
Laundry Detergent on Clothes

1 THINGS YOU CAN TASTE

Mints
Gum
Food

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