GRANVILLE EXEMPTED VILLAGE SCHOOLS
SCHOOL HEALTH SERVICES
Individualized Health Plan

Student: **DOB:** **School Year:**

IHP Completed by: Gina Burdick, MSN, RN, LSN – District Nurse

Background:

Nursing Diagnosis:

Risk of inadequate breathing related to exposure to

Goals/Objectives:

Student will not be exposed to

Actions/Interventions: See below and attached Allergy Action Plan. Please make any additions or deletions below.

ALLERGIC REACTION/TREATMENT

Forms with physician's signature submitted by parent before school begins
Follow specific treatment in Food Allergy Action Plan

STUDENT'S SUPPLIES (epinephrine injector, antihistamine)

Supplied by parent before child begins classes
Location **(classroom and clinic)**
Field trip supplies (two epinephrine injectors and antihistamine)

PREVENTION OF ALLERGIC REACTION

LETTER TO CLASSROOM PARENTS (sample available to teachers)

Address severity of food allergies
Actions parents should take (teacher no sharing, send non-food items for parties, check with student's parents before sending party foods)

STUDENT EDUCATION (The Elephant Who Couldn't Eat Peanuts)

No sharing of food
Students who eat nuts or their products must wash their hands.
Desks where students had nuts must be washed- n/a if classroom is designated as nut free.

LUNCH

Nut-free table (may have friends with no-nut product lunches sit with them)

No sharing
Eats only food sent by parent
Always packs
School lunch (MD form submitted to Granville Schools lunch program)

SNACKS
No sharing
Eats only snacks sent by parent
Always packs
Snacks supplied by parents to be kept in classroom

PLANNED PARTIES
No sharing
Party foods are checked out with student's parents
Family sends special food for parties
Foods supplied by parents kept in classroom may be substituted

INCIDENTAL TREATS – prohibited by Granville schools- only if allowed- very rare
No sharing
Foods supplied by parents kept in room to be substituted

FIELD TRIPS
Check with parent on attendance
Parent packs student's lunch
No sharing
Check to be sure experience is nut-free (exhibits, manipulatives)
Both Epinephrine injectors and antihistamine should be taken

CLASS MANIPULATIVES AND PROJECTS
No peanuts or nuts or their products can be used.

SIGN ON CLASSROOM DOOR (Nut-Free Zone)

SUBSTITUTE INFORMATION
Sub folder needs to contain each student's allergy information with their pictures.

Expected Outcomes:

Staff will be aware of student's allergens and will recognize signs and symptoms of an allergic reaction.

Other considerations:

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School Health Care Action Plan:

To assist your child in maintaining optimum health, it is necessary for the school to have current information regarding his diagnosis.

Please be aware that:

1. A nurse may not always be available when a situation arises. When the nurse is not in the building, the parents or emergency medical assistance (911) will be notified depending on the state of the symptoms.
2. If equipment is needed, this must be provided by the family.

Please complete the attached forms and return to the school nurse as soon as possible. Also, continue to keep the school nurse updated on your child's changing health needs.

Medications In Case of Emergency: ____

Special Considerations and Precautions:
____
____
____
____
____

- A cell phone or other emergency communication device should always be available.

Any further instructions regarding symptoms episode management at school:
____
____
____

____
Doctor's Signature (if applicable) **Date**

____
Print Name

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Parent Consent for Management of Health Condition at School

I, ____, the parent or guardian of the above named student, request that this emergency action plan be used to guide care for my child. I agree to:

1. Provide necessary supplies and equipment.
2. Notify the school nurse of any changes in the student's health status.
3. Notify the school nurse and complete new consent for changes in orders from the student's health care provider.
4. Authorize the School Nurse to communicate with the primary care provider/specialist about my student's medical condition as needed.
5. School staff interacting directly with my child may be informed about his/her special needs while at school.

I, this child's parent/guardian hereby authorize the named healthcare provider who has attended my child to furnish to the School Health Services or School Clinic staff any medical information and/or copies of records pertaining to my child's chronic health condition, and for this information to be shared with pertinent school staff. I understand that HIPAA regulations limit disclosure of certain medical information. However I expressly authorize disclosure of information so that my child's medical needs may be served while at school. This authorization expires as of the last day of this school year.

____

Parent/Guardian Signature **Date**

____

Nurse Signature **Date**