Lake Washington School District

LWSD Health Services

Individual Health Plan (IHP)

Student Name: _____ **DOB:** _____

School: _____ Year: _____

Grade: _____ Student #: _____

Teacher: _____

Transportation: ☐ Walker ☐ Bus ☐ Parent/Guardian ☐ Student Driver ☐ Other: _____

Allergies: ☐ No ☐ Yes If yes, list: _____

Medication at School: ☐ No ☐ Yes If yes, list: _____

• Location of Medication at School: ☐ Health Room ☐ Self-Carry Location: _____ ☐ Other: _____

Medication at Home: ☐ No ☐ Yes If yes, list: _____

Preferred Hospital: _____

Health Concern / Diagnosis:

Symptoms Experienced Due to the Above Diagnosis:

Relevant History (additional diagnoses or health concerns):

Staff Instructions and Interventions:

Student Responsibilities:

Additional Health Information (Optional):

Supplementary Information:

Before signing, parent/guardian should review and complete this IHP in its entirety. A new IHP must be submitted each school year. The School Nurse must be notified if any changes are needed to this plan during the school year.

- LWSD schools do not staff a nurse on site during all school hours.
- Teacher will communicate medical concerns to their substitutes by placing a copy of each health plan in the substitute file.
- School Nurse will ensure a copy of the health plan is kept in the health room, available for field trips, and in Skyward for staff.
- According to Washington State Law (RCW 28A.210.320), the attendance of every child shall be conditioned upon the presentation before or on the child's first day of attendance, a medication of treatment order addressing any life-threatening health condition that the child has that may require medical services to be performed at school. Once such an order has been presented, the child shall be allowed to attend school.
- Regarding Disaster Planning in Schools: In the event of a major disaster, such as a severe earthquake, the school may be responsible for the care of students for up to 72 consecutive hours. It is recommended that parents provide the school with a 72-hour supply of medications taken daily at home, if applicable.

Parents / Guardians:

Name	Relationship	Primary Number	Other Number	Address
Additional Contact (optional):				

Parent Name (Print): _____

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Confidential Information - shred prior to discard