Bellevue School District CROHN'S Individual Health Plan

Name:	_____	Birth Date:	_____	
School:	_____	Grade	_____	

CROHN's (Inflammatory Bowel Disease): A condition that causes inflammation and thickening of the digestive tract with associated gastrointestinal symptoms. It can have periods of remission and flare-ups. It is managed with medical, surgical, nutritional, and psychological support.

TYPICAL SYMPTOMS (If applicable):

☐ Constipation ☐ Diarrhea ☐ Gas ☐ Bloating ☐ Vomiting ☐ Rash ☐ Fatigue ☐ Other: _____

FOOD RESTRICTIONS: _____

EMERGENCY CARE PLAN

Allow unrestricted bathroom use throughout the day.
Consider seating in proximity to door.
May require oral medication.
Increased susceptibility to gastrointestinal illnesses than average students – take illness precautions in classroom; encourage frequent handwashing.

MEDICATION/TREATMENT ORDERS: *Can be filled out by licensed health care provider; MD, DO, ND, DMD, DC, PA, ARNP, CNM. IHP can be filled out by School Nurse based on BSD "Medication Authorization Form – 3416P Exhibit A" or other completed provider orders. *In accordance with RCW 18.79.040, if a registered nurse is on site, they may utilize the nursing process, which includes assessment, specialized knowledge, judgment, and skill in determining plan of care or treatment.*

Licensed Health Care Provider's signature: _____ *Signature authorizes medication for length of school year*	**Date:**	_____	**Phone:**	_____
	School year:	_____	**Fax:**	_____

PARENT/GUARDIAN/STUDENT (age 18 and older) RESPONSIBILITIES:

- I will notify the school nurse of any changes in health status or healthcare provider instructions.
- If my student attends extended day/childcare, clubs before- and after-school, evening, and summer activities, I will notify the program director of my student's medication and health care needs.

I agree to hold harmless and indemnify the school and Bellevue School District's officers, employees, and agents against all claims, judgments, or liabilities arising out of any injury resulting from reasonable and prudent administration of medication, the reasonable performance of health care procedures, or the liabilities arising out of self-administration and self-carrying of medication by my student/me. BSD staff have been trained to assist with medication administration.

I accept this Individual Health Plan. *My signature gives permission for exchange of information between the School Nurse and the Health Care Provider regarding this medication order.*

Parent/Guardian/Student (age 18) signature: _____	**Date:**	_____	**Phone:**	_____
				_____

INDIVIDUAL CONSIDERATIONS:

Classroom:

- Teacher to inform substitute teachers of the student's Individual Health Plan

Field Trip Procedures: Students who self-carry are responsible for their own medication. Medication and IHP will accompany student during any off-campus activity.

School Nurse: Will notify teachers, other school staff, transportation, and nutrition services of student's IHP

Please return to:

School Nurse: _____	**Email:**	_____@bsd405.org	**Phone:**	425-456-_____
			Fax:	425-456-_____

Updated 2/23/26

See also BSD Policy/Procedures: 2410 Student Health; 3418 Emergency Treatment
Other Resources: https://www.crohnscolitisfoundation.org/sites/default/files/legacy/assets/pdfs/a-guide-for-parents.pdf