Bellevue School District **NEUROMUSCULAR Individual Health Plan**

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

_____ (diagnosis) **:** _____ (description)

CURRENT <u>HOME</u> MEDICATION*:	**Dose/Time:**	**Side Effects:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.*

EMERGENCY CARE PLAN

<u>CALL 911 FOR STUDENT WITH NEUROMUSCULAR DISORDER WHO SHOWS SIGNS OF RESPIRATORY DISTRESS, SUDDEN WEAKNESS, LOSS OF CONSCIOUSNESS, OR WORSENING SYMPTOMS.</u>

CONSIDERATIONS FOR SCHOOL:

- At risk for falls – no stair use. Student should use the elevator.
- Allow for flexibility with seating options – chair vs. sitting on the floor.
- Allow for use of scooter
- Student to self-limit activity.

AT RISK FOR ILLNESS:

- Notify family of an increase in illness pattern in his classroom.
- Immediately notify family of any known case(s) of chickenpox, shingles, or measles

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.
- I will keep track of expiration dates for the medication(s) and replace if expired or used.
- I will provide prescription medication(s) in original pharmacy container labeled with student name, medication name, strength of medication, dose, and time of administration OR I will provide non-prescription medication in the original container with the student name.
- I understand for "self-carrying" medication, back-up medication in the health room is recommended.
- Students who "self-carry" medication are responsible for carrying medication during school and for all school clubs, activities, sports, field trips.
- 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.

PARENT/GUARDIAN/STUDENT (age 18 and older) - <u>Please check only one box & sign below:</u>

☐ I request that I/my student be allowed to **self-carry and/or self-administer this medication**.

☐ If I do not/my student <u>DOES NOT</u> self-carry, I request that the authorized/trained person(s) at school assist me/my student in taking the medicine(s) described above.

If I/my student has permission to <u>SELF-CARRY and/or SELF-ADMINISTER THIS MEDICATION</u> I/my student understands the responsibility of self-carrying medication at school and recognizes the school will not track compliance, expiration, or amount.

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:**	

<u>INDIVIDUAL CONSIDERATIONS:</u>

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

<u>Please return to:</u>

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

Updated 2/23/26