Chesterfield County Public Schools
Office of Student Health Services

Request for Individualized Healthcare Plan

Dear Parent/Guardian:

Providing a safe, supportive and nurturing environment is a goal of Chesterfield County Public Schools (CCPS). The health information provided for your child indicates that he/she has a health concern. To adequately meet your child's health needs while in school, please do the following as soon as possible:

1. Have your licensed healthcare provider (physician, physician's assistant or nurse practitioner) complete and sign the attached Individualized Healthcare Plan (IHP). IHPs are also available online at http://mychesterfieldschools.com/parents/student-health-and-safety/.

2. Provide your signature on the IHP. Signing the IHP certifies that:
   - You understand school staff and/or the school nurse may communicate with the Licensed Healthcare Provider/medical office staff about the IHP.
   - You understand you are responsible for providing the school with all medication for your child in the original container per Chesterfield County School Board policy 4130/4130R *Administration of Medication to Students.*
   - You understand you are responsible for completing the Chesterfield County Public Schools School Medication Record for medication ordered in this health plan.
   - You understand emergency medication you provide will be administered as ordered by the Licensed Healthcare Provider.
   - **You agree to this health plan for your student.**

3. Return the completed plan to the attention of the school nurse at the school your child will be or is attending.

It may be necessary for some students to carry and self-administer emergency medication. This requires proper documentation by a licensed healthcare provider on the appropriate health plan. Permission for a student to possess and self-administer medication (for example auto-injectable epinephrine or medication to manage asthma or diabetes) is effective for one school year and must be renewed annually. Please consult with your school nurse for details.

If medication is needed for your child, complete the CCPS School Medication Record form required for all medications that students take during the school day. This form is available in the school clinic and at http://mychesterfieldschools.com/parents/student-health-and-safety/**. Medication must be provided by the parent/guardian and brought to school by the parent/guardian in the original appropriately labeled container. See the CCPS website for details regarding the medication policy and regulation (4130 and 4130R).**

For students with a life-threatening food allergy, the Food Allergy Medical Statement must be completed by a physician, physician's assistant or nurse practitioner if the child needs any of the following: to be identified by cafeteria staff as having a life-threatening allergy; if child is lactose intolerant; if substitutions or food modifications need to be made in the school breakfast or lunch programs. The Cafeteria Manager at school must also be notified. For assistance you may contact the Nutritionist, CCPS Food & Nutrition Department, at (804) 743-3717.

A health condition may be considered a disability. If you suspect your child may have a disability, ask your child's teacher, counselor, school nurse or administrator for a referral to consider eligibility for 504 or special education services.

If you have any questions, call the registered nurse at your child's school. We appreciate your prompt attention to this matter. Thank you for partnering with us to support your child's well-being in school.

Sincerely,

Chesterfield County Public Schools
Office of Student Health Services

1st notice _________

2nd notice _________

Attachment

Healthcare Plan effective for the current school year, including summer school.

Chesterfield County Public Schools
Office of Student Health Services

AAA-1075(IHP-LTA)

INDIVIDUALIZED HEALTHCARE PLAN

ANAPHYLAXIS/LIFE-THREATENING ALLERGIC REACTION

***Section 1* – To be completed by Licensed Healthcare Provider (Physician, Physician's Assistant or Nurse Practitioner).**

STUDENT NAME:		Date of Birth:
ICD-10: Grade:	School:	

ALLERGY HISTORY

Student has a life-threatening allergy to: ☐ Food ☐ Latex ☐ Insect ☐ Other, specify:____________________________

Symptoms occur due to: ☐ Ingestion ☐ Inhalation ☐ Touch/skin contact ☐ Injection/sting ☐ Unknown

- **Please list food allergens:** ___________________________________
- **Does student have asthma?** (increased risk factor for severe reaction) ☐ Yes ☐ No
- **Approximate date of last anaphylactic reaction**: _______________

TREATMENT PLAN

To Licensed Healthcare Provider: This is the standard emergency plan for responding to anaphylaxis provided by Chesterfield County Public Schools. ***Please review.***

COMMON SYMPTOMS ASSOCIATED WITH ANAPHYLAXIS:	
• Swelling of the lips, tongue, throat or face	• Coughing, sneezing, hoarseness, nasal congestion
• Hives; generalized flushing and itching of the skin	• Difficulty swallowing, nausea, vomiting, abdominal cramping
• Difficulty breathing, wheezing, chest tightness	• Tingling sensation or warmth, metallic taste in mouth
	• Dizziness, faintness, feeling of apprehension, "feeling funny"

If student develops symptoms as a result of exposure to a known or suspected allergen(s):

- Administer epinephrine auto-injector: (check one) ☐ EpiPen® ☐ Auvi-Q® ☐ Adrenaclick® ☐ Generic Epinephrine Injection

  Dosage (check one): ☐ 0.3 mg IM (child weighs > 66 lbs) **OR** ☐ 0.15 mg IM (child weighs < 66 lbs)
  ☐ Other dosage: ____

  Frequency: Repeat epinephrine dose 5 - 15 minutes after the first injection, if symptoms persist or return.
- **Call 911.** Advise EMS anaphylaxis is suspected and epinephrine has been given.
- Keep student lying down or seated.
- Notify parent if not already contacted.
- Remain with student and observe for difficulty breathing until EMS personnel arrive.
- Start CPR if breathing or heart stops.

Unless noted below by Licensed Healthcare Provider, I am in agreement with the above plan:________________________________
____
____

Unless noted below by Licensed Healthcare Provider (LHP), medication will be stored in the clinic and administered by trained staff

☐ Student can physically carry his/her epinephrine auto injector

☐ Student has been instructed and can safely and effectively self-administer his/her epinephrine auto injector

____

Licensed Healthcare Provider Name (PRINT) LHP Signature NPI # Phone Number Date

To be Reviewed and Signed by PARENT/GUARDIAN:

☐ **I have reviewed this health plan and the *Request for Individualized Healthcare Plan* and agree to the contents.**

☐ Student requires a specialized eating location.

☐ Student can have food provided only by parent/guardian.

A health condition may be considered a disability. If you suspect your child may have a disability, request a referral to consider eligibility for 504 or special education services.

__________________________ __________________________________ ______________

Parent/Guardian Name (print) Parent/Guardian Signature Date Phone Number

_______________________________________ _____________ _________________

School Nurse Name/Signature Date Received Date EAP Distributed

Revised 3/2019