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 health 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 the IHP 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,

1st notice _____
2nd notice _____
Attachment

Chesterfield County Public Schools
Office of Student Health Services

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

Chesterfield County Public Schools
Office of Student Health Services

ICD-10: _____

Individualized Healthcare Plan – Asthma

Student Name:	**DOB:** _____	**Grade:** ____	**School:** _____

To be completed by LICENSED HEALTHCARE PROVIDER (Physician, Physician's Assistant or Nurse Practitioner)

What triggers child's asthma?

☐ Illness/colds ☐ Smoke ☐ Strong odors ☐ Pollen ☐ Dust ☐ Mold/moisture ☐ Dog ☐ Cat ☐ Exercise ☐ Acid reflux
☐ Stress/Emotions ☐ Season/Weather _____ ☐ Food:_____ ☐ Other_____

What symptoms does child experience during an asthma episode? (Check all that apply)

☐ Cough ☐ Shortness of breath ☐ Tightness in chest ☐ Wheezing ☐ Tired/weak ☐ Other_____

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise Induced

WELL Zone: GO!

- Student has ALL of these:
  - Breathing is easy
  - No cough or wheeze
  - Can work and play without activity restrictions
  - Able to sleep through the night
  - Peak flow: _____ to _____
    (More than 80% of Personal Best)

Personal best peak flow:_____

Student will take these CONTROL (PREVENTION) medications EVERY day

Inhaled controller medications taken at home:

☐ Aerospan ☐ Advair ☐ Alvesco ☐ Asmanex ☐ Budesonide ☐ Dulera
☐Flovent ☐QVAR ☐Pulmicort ☐Symbicort ☐Other_____
____puffs inhaler____times per day OR _____nebulizer treatment(s)_____times a day

For asthma with exercise, ADD:

Inhaler: ☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent),
2 puffs with spacer 15 minutes before exercise (PE class, recess, sports)

☐ No control medications required

SICK Zone: CAUTION!

- Student has **ANY** of these:
  - Cough or mild wheeze
  - Tightness in chest
  - Difficulty breathing
  - Not able to do usual activities
  - Problems sleeping at night
  - Peak flow: _____to _____
    (60% - 80% of Personal Best)

Give RESCUE Medications

INHALER:

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)
_____ puffs with spacer every _____ hours as needed

NEBULIZER:

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)
one unit dose treatment every _____ hours as needed

SCHOOL ACTION: Call 911 if no improvement or symptoms worsen. Call Parent.

EMERGENCY Zone: DANGER!

- Student has **ANY** of these:
  - Can't talk, eat, or walk well
  - Medicine not helping
  - Breathing hard and fast
  - Blue or gray lips or fingernails
  - Tired or lethargic
  - Chest or neck pulls in with breathing
  - Peak flow: less than _____
    (Less than 60% of Personal Best)

Call 911 and treat as below

INHALER:

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)
_____puffs with spacer **every 15 minutes**, for **THREE** treatments

NEBULIZER:

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)
one unit dose treatment **every 15 minutes**, for **THREE** treatments

SCHOOL ACTION: Call 911 immediately. Call parent.

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 inhaler

☐ Student has been instructed and can safely and effectively self-administer his/her inhaler

_____

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.**

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**