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.
   - 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 the current school year, including summer school.

Chesterfield County Public Schools
Office of Student Health Services
INDIVIDUALIZED HEALTHCARE PLAN - SEIZURE

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

To be completed by Licensed Healthcare Provider (Physician, Physician's Assistant, or Nurse Practitioner):

SEIZURE HISTORY

Seizure Type (check all that apply)	**Description: Location, frequency, duration**	
Primary Generalized Seizure: ☐ Tonic/Clonic Seizures ☐ Absence Seizures ☐ Myoclonic Seizures ☐ Atonic Seizures **Partial Seizure:** ☐ Simple Partial Seizure ☐ Complex Partial Seizure		**Describe a "seizure emergency" for this student:**
Seizure triggers or warning signs:	**Student's response after a seizure:**	

BASIC SEIZURE FIRST AID:

DO NOT REMOVE STUDENT FROM AREA unless student is in an unsafe environment

- Stay calm and track time
- Keep child safe; position on side; place something soft under the head; remove other students from the immediate area
- **Do not restrain**
- **Do not put anything in mouth**
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic (grand mal) seizure:

- Protect head, turn child on side
- Keep airway open/watch breathing

SEIZURE EMERGENCY PROTOCOL:

- Administer emergency medications as indicated below
- If student stops breathing and/or has no pulse – **BEGIN CPR**
- Call 911 for transport to hospital for seizure lasting longer than _____ minutes

NOTE: If time is not indicated, 911 will be called for seizure lasting 5 minutes or longer.

- Notify parent or emergency contact

Other:

Call 911 if:

Student has seizure lasting longer than 5 minutes (unless specified in **EMERGENCY PROTOCOL**)
Student has repeated seizures (seizure stops and starts again)
Student cannot be awakened after seizure
Student has breathing difficulties
Diastat is administered
Student has diabetes
Student is injured during seizure
Student is pregnant

Emergency Medication/Treatment		**Dose**	**Instructions**
Rectal Diazepam/Diastat	☐ Yes ☐ No		
Vagus Nerve Stimulator	☐ Yes ☐ No		Describe magnet use:
VP Shunt	☐ Yes ☐ No	N/A	
Other:			

Does this student's Diastat need to be with the student: Check all 3 columns to the right **(Note: if "No" is checked, medication will be kept in the school clinic during the school day)**			
	In the school building?	☐ Yes	☐ No
	On the bus?	☐ Yes	☐ No
	On community outings during the school day?	☐ Yes	☐ No

After a seizure:

- Place student on side to allow drainage of secretions and monitor breathing.
- Remain with student until he/she has regained pre-seizure mental and physical senses and is oriented to surroundings.
- Provide privacy and allow student to rest.
- Do not give food or drink until fully awake.
- Inform parent, clinic and EMS personnel (if called) of observed seizure, medication given and post-seizure activity

_____

Licensed Healthcare Provider Name (Print)/Signature Date NPI# Phone Number

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 Emergency Action Plan Distributed