

**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:
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: <ul style="list-style-type: none">• Swelling of the lips, tongue, throat or face• Hives; generalized flushing and itching of the skin• Difficulty breathing, wheezing, chest tightness	<ul style="list-style-type: none">• Coughing, sneezing, hoarseness, nasal congestion• Difficulty swallowing, nausea, vomiting, abdominal cramping• Tingling sensation or warmth, metallic taste in mouth• Dizziness, faintness, feeling of apprehension, “feeling funny”
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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: 0.3 mg IM (child weighs > 66 lbs) **OR** 0.15 mg IM (child weighs < 66 lbs)
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				
<input type="checkbox"/> Student can physically carry his/her epinephrine auto injector				
<input type="checkbox"/> Student has been instructed and can safely and effectively self-administer his/her epinephrine auto injector				

Licensed Healthcare Provider Name (PRINT)	LHP Signature	Date	NPI #	Phone Number
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To be Reviewed and Signed by PARENT/GUARDIAN:			
<input type="checkbox"/> I have reviewed this health plan and the <i>Request for Individualized Healthcare Plan</i> and agree to the contents.			
<input type="checkbox"/> Student requires a specialized eating location.			
<input type="checkbox"/> 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