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,

Chesterfield County Public Schools
Office of Student Health Service

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

Chesterfield County Public Schools
Student Health Services

AAA-1075(IHP-Hypoglycemia)

INDIVIDUALIZED HEALTHCARE PLAN - HYPOGLYCEMIA
(UNRELATED TO THE DIAGNOSIS OF DIABETES)

Student Name:_____ **DOB:**_____ **School:**_____

PROBLEM: Low Blood Sugar (Hypoglycemia) **ICD-10:** _____

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

SYMPTOMS: (circle those that apply to this student)

Hunger	Shakiness	Dizziness	Confusion
Difficulty speaking	Feeling anxious or weak	Irritability/nervous	Pale, sweaty

PREVENTION:

- As a preventative measure, allow the student to eat a protein/carbohydrate snack**:**
  - ☐ as needed
  - ☐ at specific time(s): _____
  - ☐ before physical activity
  - ☐ after physical activity

  Suggested snacks: _____

INTERVENTION:

- **If student develops symptoms of hypoglycemia, the following should occur:**
  - If student is able to eat, allow student to eat a snack - Call for assistance if student is unable to eat.
  - If no improvement in 15 minutes, check student's blood sugar level (if student is unable to self-check)
    - ☐ Yes (Parent to provide glucometer and test strips)
    - ☐ No
  - If blood sugar level below _____, or student remains symptomatic, **give student a food item high in sugar:**
    - 3 or 4 glucose tablets **or**
    - 4 ounces of fruit juice/soda (NOT low sugar/sugar free) **or**
    - 6 Life Saver® candies **or**
    - 1 small tube Glucose/Cake gel
    - Other _____
  - If no improvement in 15 minutes, **repeat high-sugar food item** and call parent.
- **CALL 911 IF STUDENT BECOMES UNRESPONSIVE, IS UNABLE TO FOLLOW DIRECTIONS OR IS UNABLE TO SWALLOW.**
- Other information specific to this student:

_____

_____

____

_____

__

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

Parent/Guardian, please review the following and sign below:

- I understand school staff and/or the school health nurse may communicate with the Licensed Healthcare Provider/medical office staff about this health plan.
- I understand I am responsible for providing the school with all medication for my child in the original container per Chesterfield County School Board policy 4130/4130R *Administration of Medication to Students.*
- I understand I am responsible for completing the Chesterfield County Public Schools School Medication Record for medication ordered in this health plan.
- I understand snacks and supplies I provide will be administered as ordered by the Licensed Healthcare Provider.
- **I agree to this health plan for my child.**

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 Signature **Print Name** **Date** **Phone Number**

_____

School Nurse Name/Signature **Date Received** **Date EAP Distributed**