Hartford Union High School District

Date:___________

Individualized Healthcare Plan

THIS FORM NEEDS TO BE REDONE EVERY NEW SCHOOL YEAR

additional forms and medication cards available online under services/health services

Parents: Complete, print, ***sign*** *& have* **physician signatures** *if necessary, & return this form to the Health Office or mail to:*

HUHS
Attn: Health Technician
805 Cedar Street
Hartford, WI 53027

or fax: 262-673-8943
HUHS Health Office Phone number: 262-670-3203

Student picture

Student's Name: Birthday: School Year: Grade:

HEALTH CONDITION(s): ***For asthma, allergies, diabetes or seizures, see the special sections on the back of this form***

SYMPTOMS:

SIGNS OF AN EMERGENCY:

Comments____

*Students given an Epi-Pen, Glucagon, having a seizure (greater than 5-10 minutes) or with significant difficulty breathing will require transport to the nearest medical facility. **Students who staff feels have any other life-threatening emergency; will be transported to the nearest medical facility.**

Attach additional information or instructions as needed relating to specific medical problems to this form.

Prescription medications (including but not limited to Epi-pens, Glucagon and insulin) taken at school need a ***MEDICATION CARD*** obtained from Health Technician OR online, and signed by the students physician and parent. Over-the-counter medications may be self-administered by the student if the student is responsible and understands what it is for and when to take it. All medication must be provided from home, in the original container, have the student's name on it, dosage and frequency. If your child requires help taking over-the-counter medication(s), please contact the Health Technician for more information.

Required signatures on back

turn over please

If you feel your student's medical condition may affect their school attendance (please refer to Attendance Policy), causing them to miss more than the allotted absences for each semester/year, please contact the Dean of Students at 262-670-3200.

<u>ASTHMA MANAGEMENT PLAN:</u> **Identify what triggers an asthma episode (check each box that applies) -**

☐ Exercise ☐ Strong odors or fumes
☐ Respiratory infections ☐ Chalk dust
☐ Change in temperature ☐ Carpets in the room Other____
☐ Animals ☐ Pollens
☐ Food ☐ Molds

Comments____

Current Asthma Medications and dose(s)____

I have instructed ___________________________________in the proper way to use his/her asthma medications and it is my professional opinion this student should be allowed to carry and use that medication by him/herself. **(Physician signature <u>required</u> below.)**

My child may have a nebulizer treatment with Albuterol 0.083% (Albuterol provided by HUHS), if the Health Technician feels it is medically necessary due to difficulty breathing, wheezing, and/or not having asthma inhaler with them:
___ yes ___no <u>If no,</u> an ambulance will be called for transport to the nearest medical facility.

<u>SEIZURE MANAGEMENT PLAN</u>

Type of seizures:

What does seizure look like and how long does it usually last?

List any environmental control measures, pre-medications or triggers, which should be avoided in order for the student to prevent a seizure episode.

Names of seizure medication(s) student is taking and doses: ____

<u>SEVERE ALLERGY & NONSEVERE ALLERGY MANAGEMENT PLAN</u>

Severe Allergy to:

Nonsevere allergy to:

Benadryl (**provided by parent**) before an Epi-Pen? ___ yes ___no Dosage____

Epi-Pen used for this/these allergies? ____yes ____no **(If an Epi-Pen is kept at school - a physician signature is <u>required</u> below)**

* Epi-Pen administration will require calling an ambulance for transport, as the dose only lasts 15 minutes or less.

How long ago was last reaction?____________ What happened?____

<u>DIABETES MANAGEMENT PLAN:</u> Please discuss with Health Technician for further info and forms, (must have Glucagon at school.)

AUTHORIZATION(s):

As the **<u>parent/guardian</u>** of ____, I ask for assistance to be provided to my child in taking the above listed medication(s) at school with the help by staff if necessary. By signing below, I agree and understand some medical information may need to be shared with other HUHS staff members other than just the Health Technician to keep my child safe at school. I give permission for my child to be transported to the nearest emergency facility if their condition warrants it. I understand this information may be shared with emergency responders to provide the best care possible for my child

****** Parent/Guardian Signature*** ____ Date________________<u>As the</u>
<u>medical professional</u> of the above named student, I ask that assistance be provided to my patient child in taking the above listed medication(s) at school by staff if necessary as authorized by the parent/guardian and myself. This includes administration of an Epi-Pen, Glucagon, Albuterol treatment, topical medications, oral medication or eye/ear drops.

*** Physician Signature ____ Date ______________________

*Required for **<u>all</u>** prescription medication taken at school

----- office use-----
Health Technician Reviewed____ Date ________________________