Boone County Schools
School Health Services Department
Individualized Health Care Plan
Initial Plan Date: _____

Student Name: _____ Date of Birth: _____

Parent/ Guardian Name: _____

Address: _____ Home Phone: _____

Mother's Cell Number: _____ Father's Cell Number: _____

Healthcare Provider(s) Name	Phone Number

Consent for mutual exchange of information signed? ☐ Yes ☐ No

Emergency Contact(s)	Phone Number

Brief Health History:

Special Health Care Needs:

Student Participation in Care:

Baseline Status (present health):

Diet:	Food Allergies and Reactions:

Special accommodations during school hours:

Boone County Schools
School Health Services Department
Individualized Health Care Plan (continued)

Student Name: _____ Date of Birth: _____

Medications	Dosage

Allergies

Health Care Plan included in:		
☐ Student Record	☐ IEP	☐ 504

Emergency Plans

Evacuations (Fire, Emergency, Etc.): _____

_____

Transportation: _____

_____

Field Trips: _____

_____

Other: _____

_____

Parent/ Guardian Signature: _____ Date: _____

Nurse Signature: _____ Date: _____

School Nurse Use Only		
Nursing review	**Dates:**	**Initials**

Boone County Schools
School Health Services Department
Individualized Health Care Plan
Procedure Information Sheet

Student Name: _____ Date of Birth: _____

Daily Care

Procedure (explain or attach explanation of care):		
Frequency:	Times:	Performed by:
Ability of student to assist:		
Suggested setting:		
Position of student during procedure:		
Equipment Used		
Daily:	Emergency:	
Storage:	Storage:	
Maintained By:	Maintained By:	
Child specific techniques or helpful hints:		
Procedural considerations or precautions:		

School Nurse Use Only		
School staff trained:	Date:	Nurse Signature:
		Date:
		Notes:

Boone County Schools

School Health Services Department

Addendum Page for Changes to Individualized Health Care Plan

Student Name: ____ Date of Birth: _____________________

Date of Review/Change	**IHP Page # Note Area of Change**	**Change or Addition Information**	**Signatures:** Parent, Nurse, Principal or Designee

Boone County Schools
School Health Services Department
Consent for Mutual Exchange of Information

Student Name: _____ Date of Birth: _____

Parent/ Guardian Name(s): _____

Address: _____

Requesting records from: _____

The purpose of this information disclosure is to best meet the student's educational, physical and emotional needs in the academic setting.

Please specify the information being requested below:

_____

_____

_____

_____

Disclose records to:	
Name:	
School:	
Street Address:	
City, State, Zip	
Telephone:	
Fax:	

Records may be mailed: ☐ Mailed ☐ Faxed

I certify that I am the parent or legal guardian of the above named child or that I am a student of majority age and have the authority to sign this release.

Signature: _____ Date: _____

This authorization is valid for the current school year only