Nursing Services Individual HealthCare Plan (IHP)
For Medicaid Purposes: Individual Treatment Plan (ITP)

To be updated annually or sooner as needed-School Year:

Student Name (Last, First):	**DOB:**	**Gender:**	**Grade:**	**School:**
Medicaid ID#:	**Current ICD CODE:**	**Health Care Provider:**	**Secondary Insurance:**	**Medical Diagnosis on File:**

Initial Assessment Summary:	**Allergies:**

Nursing Diagnosis	**Goals**	**Interventions**	**Person Responsible**
	1.		
	2.		
	3.		

Expected Student Outcome	**Expected Student Outcome**	**Expected Student Outcome**	**Expected Student Outcome**

Plan of Care Date	**Additional Assessment Information**	**Goal # Addressed**	**Medication, Treatment or Procedure**	**Dose**	**Frequency**	**Discontinue**	**Nurse Signature**

RN Print Name: _____ Signature_____ Initials_____ Date Signed _____

**If all of the medical orders will be followed by the school as written and the IHP/ITP is consistent with the medical orders, the signature of the Health Care Practitioner and the student's parent/guardian on the document will not be required. However, if the IHP/ITP is not consistent with medical orders, this document and the Parental Response Form will need to be signed.*
**EAP will be developed, if applicable*

IHP and ITP Approvals (if applicable)

This IHP/ITP is for _____ was prepared by the following nurse: Date:

RN's signature: _____

RN's name (*print/type*): _____ RN's initials: _____

Additional school staff signature (if applicable): _____

Review plan: ☐ beginning of next school year ☐ upon parent/health care practitioner/school request ☐ other: _____

IHP/ ITP Approvals (if not already obtained through the medical order)

Note: By signing this document, the parent/guardian and/or the student authorize sharing this information with school personnel who have a legitimate need for knowledge of the information.

Parent/guardian:

I agree with this plan of care for my child while he or she is at school or is attending school-sponsored functions. I agree to let the school know of changes in my child's health condition or treatment and changes to the contact information on page 1 of this individual health care plan/ individual treatment plan.

Sign name: _____

Print name: _____

Date: _____

Health care practitioner:

I agree with this plan of care while at school or attending school-sponsored functions.

Sign name: _____

Print name: _____

Date: _____

Student (if appropriate):

I agree with this plan of care for me while I am at school or school-sponsored functions.

Sign name: _____

Print name: _____

Date: _____

Health care practitioner:

I agree with this plan of care while at school or attending school-sponsored functions.

Sign name: _____

Print name: _____

Date: _____