Specialized Health Care Plan Addendum

To be used with:
Asthma Care Plan
Diabetic Care Plan
Food Allergy/Allergy Care Plan
Seizure Care Plan
Care Plans requiring training or from outside agencies

Student Name: __________________________Date of Birth: ____________

Teacher: ____________________Grade: _________ School: _______________

Medical Diagnosis: ______________________ Date: ______________________

Name of Specialized Health Care Plan: __________________________________

Staff members have been designated by the principal to perform and/or assist with the specialized care plan procedure(s) as requested by the parent/guardian of above student according to health care provider orders. School personnel will not be permitted to perform such procedure(s) relating to the Specialized Health Care Plan until the proper forms are completed, received and any necessary training is completed for the procedure(s). We request that you perform services at school related to this Specialized Health Care Plan until proper training is completed.

Circle procedure(s) indicated for Care Plans listed below:

Diabetic Care Plan:
Glucometer testing/finger stick
Ketostix testing/urine
Insulin Administration via Insulin Pen
Insulin Administration via Syringe
Insulin Administration via Pump
Change Insulin Pump site/tubing
Carbohydrate Counting
Calculate Insulin: Carb ratio
Correction Factor Calculation
Glucose/snack Administration
Glucagon Administration
Other:

Allergy Care Plans:
Emergency Medication Administration
Epipen Administration
Other:

Asthma Care Plan:
Inhaler Administration
Nebulizer Medication Administration
Emergency Medication Administration
Peak Flow Meter Usage
Other:

Allergy Care Plans:
Emergency Medication Administration
Epipen Administration
Other:

Seizure Care Plan:
Medication Administration
Diastat Administration
Seizure First Aide/Post Seizure Care
Other:

Additional Procedure(s) to be performed by school staff:

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Signatures indicate that training has occurred and that the designated staff member(s) understands and have demonstrated the activities required in utilizing this procedure(s) correctly for trainer.

Designated School Team:

Staff Member's Name Demonstrating Procedure(s)	Staff Member's Signature Procedure(s) Understood	Parent/Nurse Trainer's Signature Procedure(s) Demonstrated Correctly	Date of Training
1.			
2.			
3.			
4.			
5.			
6.			

I am the parent/guardian of ______________________________________and request that the Specialized Health Care Plan be utilized during school hours. I understand that I must provide any equipment, supplies, or medication needed to utilize this plan.

I understand that designated school personnel will follow the procedure(s) as designated in the Specialized Health Care Plan. It is also understood that FCBOE personnel are released from responsibility for any complications resulting from utilization of this procedure(s) and will not assume any liability for supervising or assisting in the utilization of this Specialized Health Care Plan.

I understand that whenever possible, the Specialized Health care procedure(s) should be provided by the family before or after school hours. Completion of this Specialized Health Care Plan authorizes Student Health Services to discuss the Specialized Health Care Plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Parent Signature: _______________________________ Date: ______________

Principal Signature ______________________________ Date: ______________

SHS 07-08