

Student  
Photo

**Individualized School Healthcare Plan (ISHP)**  
Please attach applicable procedure and physician's orders to this ISHP

**Student**

**Name:** \_\_\_\_\_ **DOB/ID #:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**School Site:** \_\_\_\_\_ **Rm. #** \_\_\_\_\_ **School Phone:** \_\_\_\_\_

**PHYSICIAN INFORMATION:**

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**EMERGENCY CONTACTS:**

<b>Name</b>	<b>Relationship</b>	<b>Phone</b>	<b>Phone</b>	<b>Phone</b>
1.				
2.				
3.				

**MEDICAL DIAGNOSIS/PROBLEM AND DESCRIPTION:**

**SYMPTOMS TO WATCH FOR:**

**HEALTH CARE ACTION PLAN:**

1. Maintain communication between the specialty team, primary care physician, and parent regarding the child's plan of care, progress, and special needs/problems.

**EMERGENCY CARE ACTION PLAN:**

**STAFF TRAINING**

The following designated staff member(s) have been trained for : \_\_\_\_\_

and

The following designated staff member(s) have been trained for : \_\_\_\_\_

**DESIGNATED STAFF:**

Printed Name and Signature	Training Date	Printed Name and Signature	Training Date
1.		5..	
2.		6..	
3.		7..	
4.		8.	

**DISTRIBUTION DATE(S):**

Principal      Date \_\_\_\_\_       Parent/Guardian      Date \_\_\_\_\_  
 Teacher (Put copy in sub folder)      Date \_\_\_\_\_       Other \_\_\_\_\_      Date \_\_\_\_\_

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_