Office of Student Health Services
Chesterfield County Public Schools

Request for Individualized Healthcare Plan

Dear Parent/Guardian:

Providing a safe, supportive and nurturing environment is a goal of Chesterfield County Public Schools. The health information provided for your child indicates that he/she has a health concern. To adequately meet your child's health needs while in school, please do the following as soon as possible:

1. Have your licensed healthcare provider (physician, physician's assistant or nurse practitioner) complete and sign the attached Individualized Healthcare Plan (IHP).
   IHPs are also available online at www.oneccps.org/page/health-and-wellness.
2. Provide your signature on the IHP.
   - You understand school staff and/or the school health nurse may communicate with the Licensed Healthcare Provider/medical office staff about the IHP.
   - You understand you are responsible for providing the school with all medication for your child in the original container per Chesterfield County School Board policy 4130/4130R *Administration of Medication to Students*.
   - You understand you are responsible for completing the Chesterfield County Public Schools School Medication Record for medication ordered in this health plan.
   - You understand emergency medication you provide will be administered as ordered by the Licensed Healthcare Provider.
   - You agree to the IHP for your student.
3. Return the completed plan to the attention of the school nurse at the school your child will be or is attending.

It may be necessary for some students to carry and self-administer emergency medication. This requires proper documentation by a licensed healthcare provider on the appropriate health plan. Permission for a student to possess and self-administer medication (for example auto-injectable epinephrine or medication to manage asthma or diabetes) is effective for one school year and must be renewed annually. Please consult with your school nurse for details.

If medication is needed for your child, complete the CCPS School Medication Record form required for all medications that students take during the school day. This form is available in the school clinic and at www.oneccps.org/page/health-and-wellness.

Medication must be provided by the parent/guardian and brought to school by the parent/guardian in the original appropriately labeled container. See the CCPS website for details regarding the medication policy and regulation (4130 and 4130R).

For students with a life-threatening food allergy, the Food Allergy Medical Statement must be completed by a physician, physician's assistant or nurse practitioner if the child needs any of the following: to be identified by cafeteria staff as having a life threatening allergy; if child is lactose intolerant; if substitutions or food modifications need to be made in the school breakfast or lunch programs. The Cafeteria Manager at school must also be notified. For assistance you may contact the Nutritionist, CCPS Food & Nutrition Department, at (804) 743-3717.

A health condition may be considered a disability. If you suspect your child may have a disability, ask your child's teacher, counselor, school nurse or administrator for a referral to consider eligibility for 504 or special education services.

If you have any questions, call the registered nurse at your child's school. We appreciate your prompt attention to this matter. Thank you for partnering with us to support your child's well-being in school.

1st notice _____

2nd notice _____

attachment _____

Sincerely,

Chesterfield County Public Schools
Office of Student Health Services

Office of Student Health Services
Chesterfield County Public Schools

Individualized Healthcare Plan

Healthcare Plan effective for the current school year, including summer school.

General
AAA-1075 (IHP-General)
Revised 6/2025

DOB: _____ **Grade:** _____

Student Name: _____ **School:** _____

To be completed by Licensed Healthcare Provider (Physician, Physician's Assistant or Nurse Practitioner):

Health Status

Diagnosis:

ICD 10:

Description of the student's medical condition:

Please list any physical, emotional, developmental, behavioral and/or communication concerns:

Relevant medical history:

Surgeries

Hospitalizations

Allergies (medication or other)

Activity

Is this student medically able to attend school? ☐ Yes ☐ No
Full day? ☐ Yes ☐ No
Comment:

Are there any expected absences related to what is described in health status?
☐ Yes ☐ No
Comment:

Full Participation in Physical Education classes and/or recess?
☐ Yes ☐ No
Comment:

Emergency Plans

Please indicate any medical interventions necessary in the event an urgent situation requires immediate action:

Transportation

Can student ride the school bus?
☐ Yes ☐ No

Is any special assistance (personnel or equipment) needed on the bus?
☐ Yes ☐ No Comment:

Current Medications

Medication	Dose	Route	Time

Student Name: _____ **DOB:** _____

☐ Male ☐ Female

Procedures

Parent/guardian collaborates with the RN School Nurse and student's healthcare provider to review and demonstrate procedures to designated school staff.

For students with G-tubes, J-tubes, colostomy/ileostomy care, catheterization, seizures or trach care, an additional specific Medical Order form or Individualized Healthcare Plan must be completed. Contact School Nurse regarding additional forms.

Dietary

- ☐ Gastrostomy tube* feeding
- ☐ Nasogastric tube* feeding
- ☐ Jejunostomy tube* feeding
- ☐ Oral Feeding Plan and/or Special Dietary needs— *call Office of Exceptional Education at 804-348-8263 and Office of Food Nutrition 804-743-3717*

**** Order for Tube Feeding Management at School*** needs to be completed in addition to this IHP.

Elimination

- ☐ Colostomy care
- ☐ Ileostomy care
- ☐ Diapers or Pull ups *(please circle)*
- ☐ Clean Intermittent Catheterization**
- ☐ Indwelling urinary catheter*
- ☐ External urinary catheter
- ☐ Urostomy pouch
- ☐ Catheterizing a stoma

**Only an RN or LPN may reinsert or remove an indwelling catheter with a physician's order and proper training. If dislodged, notify parent.*

*** Order for Catheterization needs to be completed in addition to this IHP.*

Musculoskeletal

School	Bus	
☐	☐	Cane
☐	☐	Crutches
☐	☐	Walker
☐	☐	Wheelchair
☐	☐	Prosthesis
☐	☐	Orthosis
☐	☐	Cast care
☐	☐	Body mechanics/ repositioning

Respiratory

School	Bus	
☐	☐	Oxygen
☐	☐	Nasal cannula
☐	☐	Oxygen mask
☐	☐	Pulse oximetry
☐	☐	Trach care/ suctioning**
☐	☐	Suctioning
☐	☐	Chest Physiotherapy
☐	☐	Ventilator Machine

***** Order for Tracheostomy Care*** *needs to be completed in addition to this IHP.*

Neuro

School	Bus	
☐	☐	Rectal Diazepam
☐	☐	Vagal nerve stimulation
☐	☐	Ventricular Shunt monitoring

Please describe procedures required to be done during school hours. Include equipment and time intervals.

Licensed Healthcare Provider

Licensed Healthcare Provider Name (Print) / Signature | **NPI#** | **Phone Number** | **Date**

Additional healthcare providers/specialists involved with this student's health care:

Name (Print)	Specialty	Phone

To be Reviewed and Signed by PARENT/GUARDIAN:

☐ **I have reviewed and agree to this health plan for my student and understand that school staff /school nurse may communicate with my child's Licensed Healthcare Provider (LHP) regarding this health plan. I acknowledge that I am responsible for providing the school with all medications and supplies required to implement the plan as ordered by the LHP.**

Parent/Guardian Name (Print) | **Parent/Guardian (Signature)** | **Date** | **Phone Number**

School Nurse Name/Signature | **Date Received** | **Date Emergency Action Plan Distributed**