



APPENDIX A

SAMPLE HEALTH CARE FORMS

www.kdhe.state.ks.us/c-f/special_needs_part2.html



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SAMPLE HEALTH CARE FORMS

It is recognized that each student's health care needs are unique. Therefore, it is important to determine, as part of the health care planning process, the extent of information and documentation required.

Following are sample forms to assist in the development of a student's Individualized Health Care Plan.

Individualized Health Care Plan

This provides a detailed summary of the student's health condition, the health care procedures to be provided, personnel responsible, identifying information and important contacts.

Anticipated Health Crisis Plan

Details the procedures to be followed and the personnel to be involved if or when an emergency occurs. The plan should always be attached to the Individualized Health Care Plan. A copy of this completed form should also be provided to all appropriate personnel.

Individualized Health Care Plan Checklist

A checklist to identify what health care activities and documentation has been completed for the student.

INDIVIDUALIZED HEALTH CARE PLAN¹

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Health History and Physical Assessment Information

NAME OF STUDENT _____ DATE OF BIRTH _____

PRESENT SCHOOL _____ GRADE _____

ADDRESS _____ PHONE _____

PRIMARY CARE PHYSICIAN _____

CURRENT PROBLEM/MEDICAL DIAGNOSIS _____

PERSON(2) FILLING OUT FORM _____ DATE _____

Mother only [] Father Only [] Both []

Other [] (please specify) _____

FATHER'S NAME _____ MOTHER'S NAME _____

EMERGENCY INFORMATION

Legal Custodian Phone _____ Other _____

PARENT RELATIONSHIP TO CHILD: NATURAL [] ADOPTED []

LIVING WITH: BOTH PARENTS [] FATHER ONLY [] MOTHER ONLY []

WHO ELSE LIVES WITH CHILD _____

MAJOR LANGUAGE IN HOME _____

FAMILY PHYSICIAN _____ DATE OF LAST PHYSICAL _____

INSURANCE INFORMATION

PRIMARY INSURANCE # _____ SECONDARY INSURANCE # _____

HEALTH HISTORY:

PREGNANCY AND BIRTH

PRENATAL:

- When this child was born, how old was mother? _____ father? _____
- Was this child born (1st, 2nd, 3rd, etc.) _____ of your children?
- How long was this pregnancy? _____ Was the baby born on time? _____
- What kind of problems (bleeding, cramping, etc.) or accidents happened during this pregnancy, if any?

- Did you take any medications while pregnant? _____
What and why? _____

- What kinds of problems did you have with other pregnancies? _____

PERINATAL:

- How long was your labor? _____
- Were there any difficulties during the delivery? _____ What kinds? _____

- Did you have a Caesarean Section, or regular vaginal delivery, or forceps delivery? _____
- How long did mother stay in hospital after birth? _____
- Did the baby come home with mother? _____ If not, please explain. _____
- Did baby need oxygen after birth? _____ . Did baby turn yellow enough to be treated? _____

DEVELOPMENTAL HISTORY

• DEVELOPMENTAL LANDMARKS:

- At what age did your child:
Begin to crawl? _____ Finish toilet training (bowel)? _____
Begin to walk alone? _____ Finish toilet training (bladder)? _____
Begin saying words (not mama or dada)? _____
- Did you or anyone else have serious concerns that your child was unusually small or short for age?
Please explain. _____
- Has anyone else in your family been unusually small in size or short in stature? Please explain. _____

CURRENT HEALTH HABITS AND OTHER BEHAVIOR

- Does your child feed him/herself? _____ Does he/she have any problems eating certain foods?
Good appetite or poor one? _____ Is he/she often hungry? _____
Do you feel your child gets enough to eat? _____
- How much sleep does he/she get at night? _____ Naps? _____
- Does he/she dress him/herself well? _____ Does he/she pick out his/her own clothes? _____
What does he/she need help with? _____
- Does he/she ever wet the bed anymore? _____ How often? _____
When did he/she last wet the bed? _____
- Does he/she have any habits such as thumb sucking or nail biting? _____
- How much exercise does your child get? _____
- Is there anything he/she is now particularly afraid of? _____
What is it? _____
- How much time do you think your child spends daydreaming? _____
- To your knowledge what kinds of experience has your child had with:
alcohol _____
drugs _____

PERSONALITY TRAITS

● Please indicate whether you think you child is generally:

- happy or sad other _____
- shy or out-going other _____
- generous or jealous other _____
- restless or calm other _____
- good-natured or irritable other _____
- kind to others or unkind other _____

● Does your child cry easily? _____ What makes him cry? _____

● What kind of temper does your child have? _____
 What makes him lose his temper? _____
 What does he do when angry? _____

● Does your child make friends easily? _____
 Are his friends mostly his age, younger, or older? _____

● What does your child like to do for fun? _____
 Does he prefer to play indoors or outdoors? _____

SIGNIFICANT HEALTH PROBLEMS, ILLNESS AND COMPLAINT

HEALTH PROBLEMS:

● Is your child under regular medical care for any condition? _____
 What is the condition? _____

● Is he currently taking any medications? _____ What are they? _____
 Does he have any side effects from them? _____ If so, what? _____

● Does your child have any chronic problems such as:
 asthma? _____ allergies: _____ seizures(fits)? _____
 diabetes? _____ other? _____

● Is your child frequently ill with such things as:
 colds? _____ how often? _____
 ear infections? _____ how often? _____
 other? _____ how often? _____
 other? _____ how often? _____

● What physical or mental handicaps does your child have? _____

PAST PROBLEMS:

● What operations (surgery) has your child ever had, and when? _____

 _____ What injuries has he had that were serious enough for a
 doctor's care (stitches, casts, etc.) and when? _____

- Has your child ever lost consciousness (knocked out), either from an injury or fainting? _____
Please explain. _____

FAMILY HEALTH HISTORY:

- Please list the names and ages of blood-relatives (immediate family) and what health problems each may have:

Name	Age	Relationship	Health Problems

- Has anyone else in the family (including parents) had any learning or other school problems? _____
Please explain. _____

CURRENT HEALTH CHECKLIST:

Please circle any of the following items that apply now to your child's health and explain details at the bottom:

ENT: Double vision, tearing, blurring, eye discharge, crossed eyes, colds, sore throats, earaches, stuffy nose, hearing, smelling, taste, mouth breathing, snoring, sneezing, nosebleeds, dental problems.

CARDIO RESPIRATORY: Shortness of breath, wheezing, coughing, chest pain, swelling, turning blue with exercise, cold hands or feet.

GASTRO INTESTINAL: Vomiting, diarrhea, constipation, abdominal pain, jaundice (yellow skin or eyes), bowel control, rectal bleeding, nausea, pinworm symptoms (itchy rectum).

GENITO URINAL: Urinates too frequently, pain, blood in urine, vaginal discharge, abnormal menstrual history, abnormalities of penis and testes, bladder control.

NEURO-MUSCULAR: Tingling, numbness, headaches, dizziness, seizures (fits), shaking, twitching, blackouts, problems with posture, deformities, gait, personality changes, unconsciousness, general speech.

SKIN: Itching, irritation, perspiration, growths, rash, excessive dryness, unusual skin color, nail or hair problems.

SUMMARY OF HEALTH HISTORY

NURSING EVALUATION

DATE _____ MEDICAL DIAGNOSIS: _____

NAME _____ BIRTH DATE _____ TEACHER/GRADE _____

A. PHYSICAL ASSESSMENT

GENERAL APPEARANCE:

Height _____	Percentile _____
Weight _____	Percentile _____
Vision Acuity: R _____ L _____	
Hearing Acuity: R _____ L _____	

KEY TO INTERPRETATION

- 0 = Essentially Normal
- 1 = Slight Pathology
- 2 = Moderate Pathology
- 3 = Severe Pathology

HEAD

- HAIR**
- _____ Dry
 - _____ Brittle
 - _____ Course

MOUTH & THROAT

- _____ Sores
- _____ Redness
- _____ Lymph Nodes
- _____ Teeth
- _____ Speech

MUSCLE - SKELETAL

- _____ Spine
- _____ ROM
- _____ Posture

SCALP

- _____ Nits
- _____ Flaky
- _____ Dry
- _____ Oily
- _____ Dandruff
- _____ Other

SKIN

- COLOR**
- _____ Cyanosis
 - _____ Ruddy
 - _____ Pallor
 - _____ Jaundice

NEUROLOGICAL GROSS MOTOR SKILLS

- _____ Balance on 1 foot
- _____ Hops
- _____ Skips
- _____ Jumps
- _____ Tandem walk
- _____ Catches ball

EYES

- _____ Strabismus
- _____ Exudate
- _____ Redness
- _____ Movement
- _____ Pupillary Reaction

TEXTURE

- _____ Rough
- _____ Dry
- _____ Oily
- _____ Smooth

FINE MOTOR SKILLS

- _____ Finger to nose with eyes open
- _____ Finger to nose with eyes closed
- _____ Finger to thumb
- _____ Heel to shin

EARS

- EXTERNAL**
- _____ Redness
 - _____ Swelling
 - _____ Tenderness
 - _____ Drainage

LESIONS

- _____ Rash
- _____ Acne
- _____ Cuts
- _____ Bruises
- _____ Scars

SUMMARY OF PHYSICAL ASSESSMENT

INTERNAL

- _____ Wax-Amount
- _____ Color
- _____ c/o Pain

CHEST, LUNGS, HEART

- _____ TPR
- _____ BP
- _____ HR & Rhythm
- _____ Pulses
- _____ Breath Sounds

B. NURSING CARE PLAN

NURSING PROBLEMS/DIAGNOSIS:

NURSING INTERVENTION AND RESPONSIBLE PERSONNEL:

NURSING EVALUATION OF INTERVENTIONS:

Anticipated Health Crisis

(Note: This should always be attached to the Individualized Health Care Plan)

Student's Name	Date
Physician	Phone
Medical Diagnosis	Preferred Hospital

STUDENT SPECIFIC CRISIS

IF YOU SEE THIS	DO THIS

IF AN EMERGENCY OCCURS

1. If the emergency is life-threatening, immediately call 9-1-1.
2. Stay with the student or designate another adult to do so.
3. Call or designate someone to call the principal and/or health care provider.
 - a. State who you are
 - b. State where you are
 - c. State problem
4. If the nurse is unavailable, the following staff members are trained to deal with this anticipated health crisis and to initiate the appropriate procedures:

Individualized Health Care Plan Checklist

I. STUDENT INFORMATION

Name	Birthdate
Parent/Guardian	Address
Mother Home () Work ()	Father Home () Work ()
School	Grade

II. ACTIVITIES COMPLETED

Parent/Guardian Consultation Date _____

Health Care Assessment Date _____

Health Care Plan Meetings Date _____ Date _____ Date _____

Educational Planning
(i.e., IEP or Section 504) Date _____ Date _____ Date _____

III. DOCUMENTATION COMPLETED

Referral Date _____

Physician's Order/Authorization Date _____

Medication/Treatment Record Date _____

Individualized Health Care Plan Date _____

Anticipated Health Crisis Plan Date _____

Personnel Training Plan Date _____

Transportation Plan Date _____

Student's special health care needs limited to medication only.

TO BE COMPLETED BY HEALTH CARE COORDINATOR/PROVIDER

Signature	Title
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NOTES

1. Information on pages A-2 to A-6 of this section adapted from:

Colorado Department of Public Health & Environment. (1995). *Procedure Guidelines for Health Care of Students with Special Needs in the School Setting*. (pp. 11-16 of Part I). Denver.

2. Information on pages A-8 and A-9 of this section adapted from:

Montana Office of Public Instruction. (1993). *Serving Students with Special Health Care Needs: A Technical Assistance Document*. (Section X - Sample Health Care Forms). Helena.