SAMPLE INDIVIDUALIZED HEALTH PLAN (IHP) FOR SOMEONE WITH A BLEEDING DISORDER

Name: _____

Date of Birth:

School: _____

Current Class/Group: _____

Date of Plan: _____

Review Date: _____

Photograph of student

Parent / Guardian Contacts

Contact Name:

Relationship: _____

Contact number: _____

Contact Name:

Relationship: _____

Contact number: _____

Contact Numbers

Emergency Contact Name:

Emergency Contact number:

Hemophilia Treatment Center Contact Name:

_____

Hemophilia Treatment Center Number:

_____

Bleeding Disorder:

☐ Hemophilia A (Factor VIII deficiency)

☐ Severe ☐ Moderate ☐ Mild

☐ Hemophilia B (Factor IX deficiency)

☐ Severe ☐ Moderate ☐ Mild

☐ von Willebrand disease (VWD)

☐ Type I ☐ Type IIa
☐ Type IIb ☐ Type II

Other: _____

_____

Signs he/she is having a bleeding episode:

☐ Says something hurts

☐ Warmth, swelling, redness in joint or muscle

☐ Unusual limb position

☐ Non use of a limb

☐ Cranky, irritable

☐ Bubbling or tingling in area affected

Other: _____

_____

Treatment Plan

His/Her treatment plan for a MINOR bleeding episodes (see below for description):

_____

_____

_____

_____

His/Her treatment plan for a MAJOR bleeding episodes (see below for description):

_____

_____

_____

_____

Medication

Name of medication:

Dosage: _____

Special considerations:

Medication will be stored: _____

Arrangement for delivery to school: _____

He/she receives his/her factor medication/infusions via:

☐ Catheter (med-a-port/Port-a-cath, or Broviac/Hickman catheter)

☐ Intravenous infusion into vein

☐ Other: _____

Other particular needs/issues

Physical Activities: _____

Plan for Absenteeism: _____

Notes:

_____

_____

School staff Who Have Received Bleeding Disorder Awareness Training:

Name: _____

_____

_____

_____

Date: _____

_____

_____

_____

Dr. Robert J. Underwood
Superintendent

Indian Lake Schools

6210 SR 235 North
Lewistown, Ohio 43333
937-686-8601 · Fax: 937-686-8421

Coleen Reprogle
Treasurer

March 2022

Students with any medication to be stored or given at school such as daily, emergency or as needed, must provide the appropriate updated Medication Administration form **each school year**. There is a form for prescription medications that doctors sign and a different form for over the counter medications that parents simply sign when they drop off the medication for school.

Please note that Medication Administration Forms are also required for medications that students self-carry. Ohio law only lists 3 self-carry medications for school which include inhalers, epinephrine auto injector and glucagon. **ORC 3313.718** also states that in order for students to self-carry epinephrine auto injector, a second backup is to be received by the school. There is an area on the administration form for both the doctor and parent to sign consent for the student to self-carry these medications.

Remember students are not permitted to transport medications to/from school. A parent or guardian signature is necessary for medication to be signed in/out of clinic inventory. Finally, all medication **MUST** be stored in the original container with the label matching the signed doctor's order.
For questions please contact District Nurse, Kourtney Thompson at 937-686-7323.

Sincerely,

Robert J. Underwood
Superintendent

Indian Lake Elementary School
8779 CR 91
Lewistown, Ohio 43333
Phone: 937-686-7323
Fax: 937-686-0049
Molly Hall, Principal
Pamela Scarpella, Asst. Principal

Indian Lake Middle School
8920 CR 91
Lewistown, Ohio 43333
Phone: 937-686-8833
Fax: 937-686-8993
Melissa Mefford, Co-Principal, Operations
Erin Miller, Co-Principal, Instruction

Indian Lake High School
6210 SR 235 North
Lewistown, Ohio 43333
Phone: 937-686-8851
Fax: 937-686-0024
Kyle Wagner, Principal
David Coburn, Asst. Principal

Indian Lake Local Schools
Medication Administration Form
(Including Asthma Inhaler and Epinephrine Autoinjector Use)

Student Information

Student name			Date of birth
Student address			
School	Grade/Class	Teacher	School year
List any known drug allergies/reactions		Height	Weight

Prescriber Authorization

Name of medication	Circumstance for use	
Dosage	Route	Time/Interval
Date to begin medication	Date to end medication	
Circumstances for use		
Special instructions		
Treatment in the event of an adverse reaction		
Epinephrine Autoinjector ❑ Not applicable ❑ Yes, as the prescriber I have determined that this student is capable of possessing and using this autoinjector appropriately and have provided the student with training in the proper use of the autoinjector.		
Asthma Inhaler ❑ Not applicable ❑ Yes, if conditions are satisfied per ORC 3317.716, the student may possess and use the inhaler at school or at any activity event or program sponsored by or in which the student's school is a participant.		
Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief		
Possible Severe Adverse Reaction(s) per ORC 3317.716 and 3313.718 a) To the student for whom it is prescribed (that should be reported to the prescriber) b) To a student for whom it is not prescribed who receives a dose		
Other medication instructions Does medication require refrigeration? ❑ Yes ❑ No Is the medication a controlled substance? ❑ Yes ❑ No		
Prescriber signature	Date	Phone / Fax
Prescriber name (print) Reminder note for prescriber: ORC 3313.718 requires backup epinephrine autoinjector and best practice recommends backup asthma inhaler.		

Parent/Guardian Authorization

☑ I authorize an employee of the school board to administer the above medication. ☑ I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. ☑ I also authorize the licensed healthcare professional to talk with the prescriber or pharmacist to clarify medication order.

☑ Medication form must be received by the principal, his/her designee, and/or the school nurse. ☑ I understand that the medication must be in the **original** container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

Parent/Guardian Self-Carry Authorization

❑ *For Epinephrine Autoinjector: As the parent/guardian of this student, I authorize my child to possess and use an epinephrine autoinjector, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant. I understand that a school employee will immediately request assistance from an emergency medical service provider if this medication is administered. I will provide a backup dose of the medication to the school principal or nurse as required by law.*

❑ *For Asthma Inhaler: As the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.*

Parent/Guardian signature	Date	#1 contact phone	#2 contact phone

HEA 7758 5/11

Please fax form to IL School Nurse Kourtney Thompson at 937-686-0049

❑ File per district policy