



**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 healthcare 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 and received, and all 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: Carbohydrate 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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## Specialized Health Care Plan Addendum

Signatures indicate training has occurred and the designated staff member(s) understand and demonstrated the activities required in utilizing the procedure(s) correctly for the 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 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 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 of any complications resulting from utilization of the procedure(s) and will not assume any liability for supervising or assisting in the utilization of this Specialized Health Care Plan.

I understand 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 healthcare 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: \_\_\_\_\_