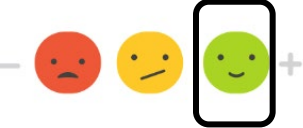


**Confidential Individualized Healthcare
Plan**

Student Name: _____ **Birth Date** _____ **School** _____ **Grade** _____

Parent/Guardian:	
Parent/Guardian:	
Healthcare Provider	
Healthcare Provider	Mental Health Provider:
Preferred Hospital:	Preferred Hospital
Emergency Contact:	Name, Relationship & Phone # (other than parent/legal guardian)
Contributing Health factors:	Anxiety Do they have 504 IEP <input type="checkbox"/> RTI
PERTINENT HEALTH HISTORY	Anxiety
ALLERGIES:	
RESTRICTIONS:	
CURRENT MEDICATIONS:	DAILY MEDICATIONS AT HOME

IF YOU OBSERVE OR STUDENT REPORTS THIS:		DO THIS:
<p>Green Zone: No symptoms present or mild symptoms</p>	<ul style="list-style-type: none"> No current symptoms to very mild symptoms- restlessness or worried thoughts Verbal Scale 0-3/10 	<p>Goal: Stay in school</p> <p>Action:</p> <ul style="list-style-type: none"> Participate in daily school activities Eat healthy foods; don't skip meals Continue to take any prescribed daily medications Drink enough water Get regular exercise Breathing techniques (see below) Check in with designated support person: _____ Other: _____

Revised and adopted by CHCO School Health Program 2020 from CDE http://www.cde.state.co.us/HealthAndWellness/SNH_HealthIssues.htm.

"This document and the information it contains was created by Children's Hospital Colorado ("CHCO") to serve as a guideline and reference tool for use by CHCO employees while acting within the scope of their employment with CHCO. The information presented is intended for informational and educational purposes only. It is not intended to take the place of your personal physician's advice and is not intended to diagnose, treat, cure or prevent any disease. The information should not be used in place of a visit, call, consultation or advice of your physician or other health care provider.

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**Confidential Individualized
Healthcare Plan**

Student Name:

Birth Date

School

Grade

<p>Yellow Zone: Student is feeling anxious and is not sure if they can make it through the school day</p>	<ul style="list-style-type: none"> • Symptoms may include avoiding activities, irritability/anger, difficulty concentrating, heart pounding, having trouble breathing, or feeling dizzy, shaky, or sweaty [<i>Ideally, identify symptoms specific to the student</i>] • Verbal Scale 4-6/10 <div style="text-align: center;"> </div>	<p>Goal: Stay in School</p> <p>Action: [<i>Identify actions that are known to be helpful for the specific student, including relevant actions in IEP or 504 or RTI</i>]</p> <p>Start with non-pharmacologic therapies that could include: (non-chronological order but can be used in order)</p> <ul style="list-style-type: none"> ○ Taking a break for ____ mins. ○ Breathing techniques (square breathing, see below; younger students can blow bubbles or feathers) ○ 5-4-3-2-1 technique (see below) ○ Listen to soothing music ○ Get a cold drink of water or using ice/ice pack or use cold compress ○ Squeeze something (play dough, clay, silly putty, your fists, a stress ball) ○ Name animals alphabetically (alligator, bear, cow, dog, etc...) ○ Give yourself a hug- squeeze tight! ○ Eat a sour candy ○ Imagine your favorite place, think of your favorite things, or remember the words to a song you love ○ Other: _____ <p>If student is still in the yellow zone after using non-pharmacologic therapies for ____ minutes, give medication: [if possible, include a specific amount of time to try non-pharmacologic therapies prior to giving medication, i.e. 10 minutes],</p> <ul style="list-style-type: none"> ○ Name of medication: _____ ○ Student can take _____ by mouth _____ as needed (maximum of _____ doses during the school day). ○ <i>Add any special medication considerations or instructions here:</i>
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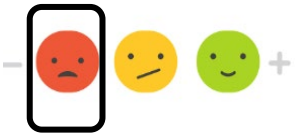
**Confidential Individualized
Healthcare Plan**

Student Name:

Birth Date

School

Grade

<p>Red Zone: Student's anxiety is at a level where they feel like they can not stay at school for the day.</p>	<ul style="list-style-type: none"> • Student is not responding to actions in Green and Yellow Zones • Symptoms may include irritability/anger, difficulty concentrating, heart pounding, having trouble breathing, or feeling dizzy, shaky, or sweaty [Ideally, identify symptoms specific to the student] • Verbal Scale 7-10/10 	<p>Goal: Stay in School</p> <p>Action:</p> <ul style="list-style-type: none"> ○ If the student comes to the health office already in the red zone, you may give the medication listed above. You do not need to do non-pharmacological interventions prior to giving the medication. Do not give a second dose if the student already received their medication in the yellow zone. ○ Inform parents that medication was given including time, dose and brief description of circumstance (many can have side effects if parents aren't aware and administer another dose at home too soon) ○ If student does not improve in ___ mins after interventions, call parents again to discuss next steps. ⊗ [Add any special medication considerations or instructions here.] <p>Call 911 if you see the following:</p> <ul style="list-style-type: none"> ○ Active self-harm or harm to others ○ Parents are unresponsive to phone call requests for the student to be picked up and their anxiety continues to be 7-10/10 ___ mins after interventions.
	<p>EMERGENCY ACTION PLAN</p> <p>Shelter in place – Per existing school plan Evacuation plan – Per existing school plan</p>	

This service is medically necessary through the following dates, not to exceed one year.

Start Date: _____ **End Date:** End of school year

TO THE PARENT/GUARDIAN: If _____ (“Student”) experiences a change in their health condition (such as a change in medication or a hospitalization) please contact the School Nurse Consultant so that this Health Care Plan can be revised, if needed. Parent/guardian signature indicates permission to contact the student’s health care provider(s) listed above, as needed. I understand that the School Nurse Consultant may delegate this health care plan to unlicensed school personnel. I give permission for school personnel to carry out this care plan for the Student. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure the Student’s safety and well-being while at school or during school related activities.

Parent/Guardian Date

School Nurse Date

Health Care Provider Date

Administrator Date

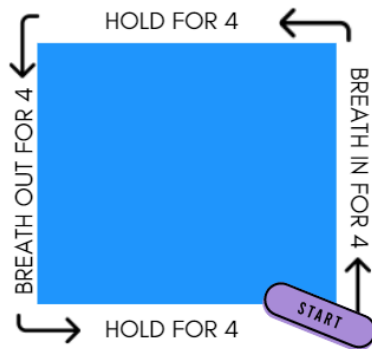
**Confidential Individualized Healthcare
Plan**

Staff trained to care for student:

1. _____
2. _____
3. _____
4. _____
5. _____

SQUARE BREATHING

- Start at the bottom right of the square
- Breathe in for four counts as you trace the first side of the square
- Hold your breath for four counts as you trace the second side of the square
- Breathe out for four counts as you trace the third side of the square
- Hold your breath for four counts as you trace the final side of the square
- You just completed one deep breath!



GROUNDING USING YOUR 5-SENSES

What are

Ideas

5

THINGS YOU CAN SEE



Sky
Trees
Birds
People
Wall Fixtures

4

THINGS YOU CAN TOUCH



Feet on the Floor
Pencil in Hand
Texture of Clothes

3

THINGS YOU CAN HEAR



White Noise
Cars Passing
Clock Ticking
People Talking

2

THINGS YOU CAN SMELL



Food
Grass
Laundry
Detergent on Clothes

1

THINGS YOU CAN TASTE



Mints
Gum
Food