Confidential Individualized Healthcare Plan

School Nurse Name and Phone #

Student Name | Birth Date | School | Grade | Student #

Parent/Guardian:	Name and Phone #
Parent/Guardian:	Name and Phone #
Healthcare Provider	Name, Relationship & Phone #
Healthcare Provider	Specialist Provider and Phone #
Preferred Hospital:	Preferred Hospital
Emergency Contact:	Name, Relationship & Phone #
CURRENT HEALTH ISSUES	Celiac disease is an autoimmune disorder that affects the small intestine. In individuals with celiac disease, consuming gluten—a protein found in wheat, rye, and barley—triggers an immune response that damages the villi, the small finger-like structures responsible for absorbing nutrients. Damage to the villi impairs nutrient absorption, which can lead to nutritional deficiencies and affect normal growth and body function.
PERTINENT HEALTH HISTORY	
ALLERGIES:	
RESTRICTIONS:	**Diet:** Avoid foods containting wheat, barley, and rye, ***Obtain a meal modification form if they are having school lunch.***
CURRENT MEDICATIONS:	**AT HOME:**
	AT SCHOOL:
HEALTH PROBLEM(S):	
Problem: Potential Gluten exposure	**Goal:** Minimize or prevent risk of exposure through staff education **Action:** • Communicate the students' dietary restrictions and health accommodations to appropriate staff (kitchen staff, teachers, etc.) • Provide education to pertinent school staff regarding celiac disease, strategies to prevent gluten exposure, and the appropriate response if accidental exposure is known or suspected. • Clean and sanitize eating surfaces and shared areas according to school protocols to minimize the risk of gluten cross-contact. • Check with parents/guardians for classroom craft items that may contain gluten. Student may be able to use and then immediately wash hands following. Teachers should be prepared to provide gluten-free alternatives to classroom material that may contain hidden gluten (ex playdoh, paper mache, pasta crafts). • Reinforce handwashing with soap and water before and after eating and after handling shared classroom materials or potential sources of gluten. Hand sanitizers are not an effective substitute for removing gluten. • Provide parents/guardians with advanced access to school meals and snack menus, when available to support safe meal planning.

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Student Name | Birth Date | School | Grade | Student #

	• Notify parents/guardians in advance of classroom activities, celebrations, or events involving food to allow for appropriate gluten-free accommodations. • Plan for field trips and school sponsored activities to ensure access to safe gluten-free food options and to minimize the risk of gluten exposure.
Problem: Gluten exposure	**Goal:** Monitor and treat gastrointestinal symptoms **Action:** **Symptoms can include but are not limited to:** Upset stomach Vomiting Diarrhea Headaches Fatigue or mood changes Student specific symptoms: _____ _____ • Allow student access to school health office and notify parents of potential or known gluten exposure. ▪ Student does not have go home for diarrhea/vomiting after a known gluten exposure if they are not experiencing other symptoms of illness ▪ Symptoms may last for a few days to weeks • Allow unrestricted access to restrooms and water. • Consider storage of change of clothes for students.
Problem:	**Goal:** **Action:**
EMERGENCY ACTION PLAN	Shelter in place Evacuation plan **Maintain an emergency supply of parent-approved gluten-free snacks and ensure access during emergency situations**

Personal Care Services/ Medically Necessary Services *(repeat segment if more than one service)*

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ICD-10 Code:

Specific task: *example: feeding, cath, diaper change*
Scope: *What is the related service that is needed for the student?*
Duration: *How long does the service take? (minutes or hours/per instance)*
Frequency: *How many times does it need to be done per day? (number times per day or as needed)*

This service is medically necessary through the following dates, not to exceed one year.
Start Date: **End Date*:***

TO THE PARENT/GUARDIAN: If Student Name experiences a change in his/her 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 child'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 Child. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure the Child'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

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