INDIVIDUALIZED HEALTHCARE PLAN (IHP)
Unspecified Condition Form

STUDENT NAME: _____**DOB**_____

Student Address:
Home Phone:
Parent/Guardian:
Day/Work Phone:
Healthcare Provider:
Provider Phone:
IHP Written By:

School:
Teacher/Counselor:
Grade:
IHP Date:
IEP Date:
Review Date(s):
ICD-9 Codes:

Parental/Guardian statement: ***I/We have read this plan and agree to its implementation.***
Signature: _____ **Date:** _____

Assessment Data	Nursing Diagnosis	Goals	Nursing Assessment	Expected Outcome

STUDENT NAME: _____ **DOB** _____

Parental/Guardian Statement: ***I/We have read this plan and agree to its implementation.***

Signature: _____ **Date:** _____

Assessment Data	Nursing Diagnosis	Goals	Nursing Interventions	Expected Outcomes