

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: _____
_____ological impairment

Date: _____
