Student

Photo

**Individualiz­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ed School Healthcare Plan (ISHP)**

**Please attach applicable procedure and physician’s orders to this ISHP**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Student Name:** | |  | **DOB/ID #:** | |  | | **Date:** | |  |
| **School Site:** |  | | **Rm. #** |  | | **School Phone:** | |  | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Physician Information:** | | | | | | | | | | | | |
| Name: |  | | | | | | Phone: | |  | | | |
| **Emergency Contacts:** | | | | | | | | | | | | |
| **Name** | | **Relationship** | | | **Phone** | | | **Phone** | | | **Phone** | |
| 1. | |  | | |  | | |  | | |  | |
| 2. | |  | | |  | | |  | | |  | |
| 3. | |  | | |  | | |  | | |  | |
| **MEDICAL DIAGNOSIS/PROBLEM AND DESCRIPTION:** | | | | | | | | | | | | |
| Leukemia is a type of cancer that affects the blood. It is characterized by an overabundance of abnormal cells in the bone marrow which can spread to other parts of the body. This over accumulation affects the bone marrow’s ability to produce normal white blood cells. The white blood cells are the cells which help to fight infection. The exact cause of leukemia is unknown. The student has Acute Lymphocytic Leukemia which is a disorder of children. Treatment is usually by chemotherapy to destroy as many leukemia cells as possible & return the bone marrow to as near as normal as possible. It usually takes 2-3 years minimum before a “cure” can be considered. | | | | | | | | | | | | |
| **SYMPTOMS TO WATCH FOR:** | | | | | | | | | | | | |
| Leukemia causes anemia, thrombocytopenia (low amounts of blood clotting cells) with symptoms of paleness, fatigue, shortness of breath & decreased activity tolerance; leukopenia (low amounts of white cells which fight off infection with symptoms of increased infections (which can be fatal) & illness and fever, swollen glands, joint swelling & pain, weight loss & lack of appetite. Central nervous system involvement is not uncommon with symptoms of irritability, nausea & vomiting, headache, personality changes, blurred vision & changes in the level of consciousness. Report symptoms observed to school nurse. | | | | | | | | | | | | |
| **HEALTH CARE ACTION PLAN:** | | | | | | | | | | | | |
| Symptoms of infection must be reported to the school nurse promptly including:   * Fever, * Complaints of illness even when vague   Good classroom hygiene must be practiced minimizing risk of illness, especially due to upper respiratory infections.   * Good hand washing * Prevent exposure to persons with illness   Adjust school environment and PE as needed to minimize fatigue and promote rest.  Report any bleeding to school nurse or parent.  Arrange for home-hospital instruction if school attendance impossible on an extended or intermittent basis.  Notify parent for any infectious disease outbreak in school (influenza, measles, chicken pox, etc.). | | | | | | | | | | | | |
| **STUDENT ATTENDANCE** | | | | | | | | | | | | |
| **No Concerns**  **Concerning Absenteeism (5 – 9.9%) Chronic Absenteeism (> 10%)**  **INTERVENTIONS**  **Parent/Guardian Contact**  **Attendance letter**  **HIPAA/MD Contact**  **Medical Referral**  **Teacher(s) Collaboration**  **SART/SARB** | | | | | | | | | | | | |
| **IN THE EVENT OF AN EMERGENCY EVACUATION** | | | | | | | | | | | | |
| The following designated and trained staff member(s): should have access to a communication device and are responsible for assuring that the student’s medication and emergency plan accompanies him/her to the evacuation command center.  The following designated and trained staff member(s): are responsible to evacuate the student following the pre-determined (attached) path of travel. If the student is unable to ambulate or utilize his/her powerchair/wheelchair, then the Med-Sled must be used to evacuate. The Med Sled is located: | | | | | | | | | | | | |
| **DESIGNATED STAFF:** | | | | | | | | | | | | |
| **Name** | | | **Training Date** | **Name** | | | | | | | | **Training Date** |
| 1. | | |  | 4. | | | | | | | |  |
| 2. | | |  | 5. | | | | | | | |  |
| 3. | | |  | 6. | | | | | | | |  |
| **DISTRIBUTION DATE(S):** | | | | | | | | | | | | |
| **Principal** | | **Date** |  | **Parent/Guardian** | | | | | | **Date** | |  |
| **Teacher** (Put copy in sub folder) | | **Date** |  | **Other** | |  | | | | **Date** | |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **School Nurse Signature** |  | | **Date** |  |
| **Parent/Guardian Signature** | |  | **Date** |  |