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:** |
| Nephrotic syndrome is a group of symptoms that include protein in the urine, low blood protein levels, high cholesterol levels, high triglyceride levels, and swelling. Nephrotic syndrome is usually caused by damage to the clusters of small blood vessels in your kidneys that filter waste and excess water from your blood. |
| **SYMPTOMS TO WATCH FOR:** |
| Signs and symptoms of nephrotic syndrome include: * Swelling (edema), particularly around your eyes and in your ankles and feet
* Foamy urine, which may be caused by excess protein in your urine
* Weight gain due to excess fluid retention
* Signs/symptoms of elevated blood pressure such as c/o a headache and/or blurred vision
* Side effects from prednisone: possible mood swings, irritability, difficulty sleeping, nausea/vomiting, stomachache, blood in the stool, or vomiting blood.
* Side effects from other treatment medications: Increase sunburn risk, lowered immune system, frequent

urination, diarrhea* Symptoms accompanied by associated fever.
 |
| **HEALTH CARE ACTION PLAN:** |
| * Exercise and P.E. participation as tolerated due to a potential for decreased endurance levels –Student is to self-regulate and inform P.E. teacher if he/she is not feeling well that day.
* If student has vomiting episodes during school hours without associated fever and feels well enough to resume classes after episode has passed – he/she is to be permitted to return to class as tolerated.
* Bathroom privileges as needed. May use health office bathroom.
* Student is to use good hand washing practices.
* Report breath with “fishy-ammonia-like” odor to health office/parents.
* Report severe headache, blurred vision to health office/parents.
* Report altered mental state, inability to concentrate, confusion, decreasing level of consciousness, seizure activity to health office/parents.
* Emergency care when indicated.
* Fluid and salt intake are prescribed by physician and parents give permission for student to self-regulate this need while at school.
* At times student will need unrestricted water/fluid access. He/she has permission to drink fluids while in class.
* When absences interfere with school instruction/assignment, student is to self-advocate and take the initiative in communicating with teachers in regards to assignments. This would include keeping up to date with on-line homework postings when available.
* Parents will encourage student’s self-advocacy for health and educational needs and will keep the school informed of any changes in his/her condition.
 |
| **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** |  |