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:** | | | | | | | | | | | | |
| In eosinophilic esophagitis, a type of white blood cell (eosinophil) builds up in the lining of the tube that connects your mouth to your stomach (esophagus). This buildup, which is a reaction to foods, allergens or acid reflux, can inflame or injure the esophageal tissue. Damaged esophageal tissue can lead to difficulty swallowing or cause food to get caught when you swallow. Eosinophilic esophagitis is a chronic immune system disease. It has been identified only in the past two decades, but is now considered a major cause of digestive system (gastrointestinal) illness. | | | | | | | | | | | | |
| **SYMPTOMS TO WATCH FOR:** | | | | | | | | | | | | |
| Signs and symptoms include:  Adults:   * Difficulty swallowing (dysphagia) * Food impaction * Chest pain that is often centrally located and does not respond to antacids * Persistent heartburn * Upper abdominal pain * No response to gastroesophageal reflux disease (GERD) medication * Backflow of undigested food (regurgitation)   Children:   * Difficulty feeding * Vomiting * Abdominal pain * Difficulty swallowing (dysphagia) * Food impaction * No response to GERD medication * • Failure to thrive (poor growth, malnutrition and weight loss) | | | | | | | | | | | | |
| **HEALTH CARE ACTION PLAN:** | | | | | | | | | | | | |
| * Staff should be aware of the side effects of the medications that student is taking. The side effects may include but are not limited to: * Parents/school nurse should be notified if any of the above symptoms or medication side effects occur, and the parents should notify the physician if indicated. * Student should be allowed to use the restroom as needed. This may be frequent and teachers should have a system in place to address these urgent needs. * If the disease affects student's ability to perform in school, causes attendance issues, or affects standardized testing, then a 504 Plan should be considered to assist student in being successful and safe at school. | | | | | | | | | | | | |
| **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** |  |