Student

Photo

**Individualiz­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ed School Healthcare Plan (ISHP)**

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

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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:** | | | | | | | | | | | | |
| Chronic renal failure (CRF) refers to a long-term irreversible kidney disorder resulting from acute illness or kidney malformation. Children with CRF frequently have growth retardation either due to the kidney disorder or the medications they must take to prevent complications. Children with CRF frequently take multiple medications including prednisone, a steroid. Side effects from prednisone can be a moon-shaped face, flushing & acne. Bone marrow reduces production of red blood cells requiring transfusions.  Student has a subclavian catheter placed under the collar bone to provide an access site to connect with the dialysis machine to remove toxic substances and wastes from the body, excessive fluid, and to regulate blood pressure. | | | | | | | | | | | | |
| **SYMPTOMS TO WATCH FOR:** | | | | | | | | | | | | |
| Signs/symptoms of elevated blood pressure (hypertension) e.g. headache,  Side effects from prednisone: behavior changes, stomach pain, blood in the stool, or vomiting blood.  Extreme fatigue, weakness, malaise due to anemia requiring red blood cell replacement.  Pitting edema of feet, legs, hands. | | | | | | | | | | | | |
| **HEALTH CARE ACTION PLAN:** | | | | | | | | | | | | |
| Exercise as tolerated due to decreased endurance levels.  Limit fluids per physician’s orders.  Limit salt and potassium intake per doctor’s orders. Child Nutrition has been notified via Meal Accommodation form signed by student’s nephrologist.  Report breath with ammonia smell.  Report severe headache, blurred vision  Report altered mental state, inability to concentrate, confusion, decreasing level of consciousness, seizure activity.  If tubing should become disconnect, a clamp should be available; pinch the tubing with the clamp or if no clamp nearby, with your fingers. Notify school nurse. If bleeding or leakage continues, contact 911 immediately.  If bleeding occurs around the site, apply firm pressure with a clean cloth for at least 10 minutes; contact school nurse and parents immediately. If bleeding is heavy or continues to ooze after 10 minutes, call 911.  Implement activities, including PE as per healthcare provider’s orders/limitations. | | | | | | | | | | | | |
| **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** |  |