****

**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:** |
| Cerebral palsy (CP) is a neuro-developmental impairment caused by a non-progressive defect or lesion in single or multiple locations in the immature brain. This defect causes cognitive and motor impairment and possible sensory deficits that are usually evident in early childhood. In cerebral palsy, faulty development or damage to motor areas in the brain impair the body’s ability to control movement and posture. This results in a number of chronic neurological disorders. Cerebral palsy is usually associated with events that occur before or during birth, but may be acquired during the first few months or years of life as the result of head trauma or infection. Cerebral palsy is neither contagious nor inherited, nor is it progressive. The symptoms of cerebral palsy (CP) differ from person to person and change as children and their nervous systems mature. Some persons with severe CP are completely disabled and require lifelong care, while others display only slight awkwardness and need no special assistance. Complications associated with CP include learning disabilities, gastrointestinal dysfunction, tooth decay (dental caries), sensory deficits, and seizures. |
| **SYMPTOMS TO WATCH FOR:** |
| Signs & symptoms of skin breakdown.Signs and symptoms of pulmonary infection, excess secretions.Signs and symptoms of bladder infection: frequency, foul smell, urgency |
| **HEALTH CARE ACTION PLAN:** |
| Maintain communication between the specialty team, primary care physician, and parent regarding the child’s plan of care, progress and special needs/problems.Maintain maximal level of skin integrity with non-restrictive clothing, safety with hot and cold, wheelchair cushions/paddings, changes of position, as needed.Provide feeding techniques as appropriate to prevent aspiration e.g position the child upright for feedings, place foods far back in the mouth to overcome tongue thrust, use of soft/blended foods.Maintain optimal musculoskeletal function with proper body alignment and posture to prevent deformities or contractures.Maintain maximal urine/bladder control.Maintains maximal stool control per bowel routine.Obtain documentation of swallowing studies/feeding evaluations as necessary.Assure any adaptive devices/braces fit and do not promote skin breakdown.Allow additional time for movement, meals. |
| **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** |  |
| **Principal/Admin:**  |  | **Date** |  |
| **General Ed. Teacher:** |  | **Date** |  |
| **SPED Teacher:** |  | **Date** |  |
| **LAMPS Teacher(s):** |  | **Date** |  |