**Logo, company name

Description automatically generated**

**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:** | | | | | | | | | | | | |
| Conversion disorder, also called functional neurological symptom disorder, is a condition in which you show psychological stress in physical ways. The condition was so named to describe a health problem that starts as a mental or emotional crisis — a scary or stressful incident of some kind — and converts to a physical problem. | | | | | | | | | | | | |
| **SYMPTOMS TO WATCH FOR:** | | | | | | | | | | | | |
| Signs and symptoms that affect movement function may include:   * Weakness or paralysis * Abnormal movement, such as tremors or difficulty walking * Loss of balance * Difficulty swallowing or "a lump in the throat" * Seizures or convulsions * Episode of unresponsiveness   Signs and symptoms that affect the senses may include:   * Numbness or loss of the touch sensation * Speech problems, such as inability to speak or slurred speech * Vision problems, such as double vision or blindness * Hearing problems or deafness | | | | | | | | | | | | |
| **HEALTH CARE ACTION PLAN:** | | | | | | | | | | | | |
| * School Nurse will meet with each teacher individually to review this ISHP * Movement dysfunction: An escort will be provided for student to get from one class to another * Student may leave class early in order to avoid student traffic during passing periods * Allow water and snack in classroom * Elevator key as needed * Allow student to come to health office as needed for rest and hydration * SEIZURE Precautions * Allow use of iPad for communication and classwork * Consider 504 Plan: if there is an increase in absenteeism to allow extra time to make-up classroom work, tests, projects, and homework assignments. | | | | | | | | | | | | |
| **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** |  |