****

**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:** |
| Depression: the manifestation of at least 5 of the following 9 criteria, with one of the first two present most of the time: 1. Depressed mood
2. Loss of pleasure or interest
3. Weight gain or loss
4. Sleeping difficulties
5. Fatigue
6. Psychomotor agitation or retardation
7. Feeling worthless
8. Inability to concentrate
9. Thoughts of suicide or death
 |
| **SYMPTOMS TO WATCH FOR:** |
| Impairment in social, academic, or overall daily functioning1. Frequent absences; late, or missed work
2. Difficulty concentrating or making decisions
3. Crying; sad, or flat affect
4. Social withdraw or isolation
5. Increase in somatic complaints, such as headache, backache, abdominal pain, etc.
6. Alteration in Self-Esteem or Body Image
7. Evidence or verbalization of intent to do self-harm
 |
| **HEALTH CARE ACTION PLAN:** |
| Active listening* Provide a safe environment for communication, taking care not to minimalize nor disregard student’s feelings
* Allow student to discuss fears, frustrations, or feelings of despair

Alleviate sense of helplessness* Offer support, and comfort as appropriate
* Provide resources for counseling and therapy as needed

Encourage family involvement * In all cases suspecting thoughts of self-harm, a parent must be notified.
* Consult with family to coordinate management of depression at school and home.
 |
| **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** |  |