**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:** | | | | | | | | | | | | |
| Inflammatory Bowel Disease (IBD)/Crohn’s disease: This is a chronic condition that causes inflammation in the digestive tract, often the small intestine and colon. The intestinal walls may become swollen and develop ulcers. The cause is unknown but may be linked to an abnormal immune system inflammatory reaction. Stress and some foods can trigger or exacerbate the symptoms. | | | | | | | | | | | | |
| **SYMPTOMS TO WATCH FOR:** | | | | | | | | | | | | |
| Symptoms can vary in severity and may start suddenly or slowly. Abdominal pain and cramping, diarrhea multiple times per day, bloody stools and weight loss may occur. In severe cases a bowel obstruction can occur which causes nausea, vomiting and a swollen belly. This would require hospital treatment. There may also be long periods of remission without any symptoms. | | | | | | | | | | | | |
| **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 IBD affects student’s ability to perform in school, causes attendance issues, or may possibly affect standardized testing 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** |  |
| **Principal/Admin:** | |  | **Date** |  |
| **General Ed. Teacher:** | |  | **Date** |  |
| **SPED Teacher:** | |  | **Date** |  |
| **LAMPS Teacher(s):** | |  | **Date** |  |