**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:** | | | | | | | | | | | | |
| Post-concussion syndrome is a complex disorder in which a variable combination of post-concussion symptoms — such as headaches and dizziness — last for weeks and sometimes months after the injury that caused the concussion.  Concussion is a mild traumatic brain injury, usually occurring after a blow to the head. Loss of consciousness isn't required for a diagnosis of concussion or post-concussion syndrome. In fact, the risk of post-concussion syndrome doesn't appear to be associated with the severity of the initial injury.  In most people, post-concussion syndrome symptoms occur within the first seven to 10 days and go away within three months, though they can persist for a year or more. Post-concussion syndrome treatments are aimed at easing specific symptoms. | | | | | | | | | | | | |
| **SYMPTOMS TO WATCH FOR:** | | | | | | | | | | | | |
| Post-concussion symptoms include:   * Headaches * Dizziness * Fatigue * Irritability * Anxiety * Insomnia * Loss of concentration and memory * Noise and light sensitivity | | | | | | | | | | | | |
| **HEALTH CARE ACTION PLAN:** | | | | | | | | | | | | |
| Student should limit both physical and cognitive exertion accordingly.   * Physical activity includes PE, sports practices, weight-training, running, exercising, heaving lifting, etc.   Until a full recovery is achieved, student may need the following supports:   * Time off from school * Shortened day * Shortened classes: rest breaks in health office   Referral to counselor for 504 evaluation if the following exists:   * Increased problems paying attention/concentrating * Increased problems remembering/learning new information * Longer time to complete tasks * Increased symptoms (headache, fatigue) during schoolwork * Greater irritability, less tolerance for stressors   Allow water and snack in classroom  Allow extra time to get from one class to another  Allow student to come to health office as needed for rest/medication  If student experiencing any of the above mentioned signs/symptoms, please escort student to health office or call for help: Never allow student to walk un-escorted to health office! | | | | | | | | | | | | |
| **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** |  |