****

**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:** |
| Pseudotumor cerebri occurs when the pressure inside the skull (intracranial pressure) increases for no obvious reason. The exact causes of “pseudotumor cerebri" in most individuals are unknown, but it may be linked to an excessive amount of cerebrospinal fluid within the boney confines of your skull. |
| **SYMPTOMS TO WATCH FOR:** |
| Symptoms mimic those of a brain tumor, but no brain tumor is present and include:* Moderate to severe headaches that may originate behind your eyes and worsen with eye movement
* Ringing in the ears that pulses in time with your heartbeat (pulsatile tinnitus)
* Nausea, vomiting or dizziness
* Blurred or dimmed vision
* Brief episodes of blindness, lasting only a few seconds and affecting one or both eyes (visual obscurations)
* Difficulty seeing to the side
* Double vision (diplopia)
* Seeing light flashes (photopsia)
* Neck, shoulder or back pain
 |
| **HEALTH CARE ACTION PLAN:** |
| 1. Obtain a signed medical release for the health provider to release educationally relevant health records and for the school to share information with the provider.
2. Obtain medical orders for headache management in the school setting.
3. With PMD orders, student may carry medication on person during the school day.
4. Allow water and snack in classroom
5. Allow student to come to the health office as needed for rest/medication.
6. Self-monitor in PE, especially during hot weather months.
7. Referral to counselor for 504 evaluation if the following exists:
8. Increased problems paying attention/concentrating
9. Increased problems remembering/learning new information
10. Longer time to complete tasks
11. Increased symptoms (headache, fatigue) during schoolwork
12. If student is experiencing any of the aforementioned signs/symptoms, please provide and escort or call the health office and we will come to get student from your class.
 |
| **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** |  |