**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:** | | | | | | | | | | | |
| **Chronic Intermittent Rectal Prolapse**: A condition that occurs when the rectal walls have prolapsed to a degree where they protrude out the anus and are visible outside the body.  This is a physical health problem that can be easily misunderstood resulting in guilt and shame. It requires that we provide support, understanding, and medical intervention. | | | | | | | | | | | |
| **SYMPTOMS TO WATCH FOR:** | | | | | | | | | | | |
| * Student is **aware (is not aware)** when he has a prolapse and can inform an adult * Pain during bowel movements * Fecal incontinence can occur with rectal prolapse * Bleeding from the rectal area * Unable to find a comfortable position, may fidget and be unable to sit * Unwilling to walk * Unable to resume activity * Anxious appearance * No relief until reinserted | | | | | | | | | | | |
| **HEALTH CARE ACTION PLAN:** | | | | | | | | | | | |
| * Student is on a bowel program to have him stool at home rather than at school. If he does have to have a bowel movement at school, he will say “\_\_\_\_\_\_\_”. * When he stools, he has a prolapse approximately 10-20% of the time. * Student can tell you “it is out.” * If student says “\_\_\_\_\_\_\_”, call the Health Office for the school nurse or health tech to take his “Go Bag of supplies” and go to the classroom to escort him to the bathroom where the changing table is (to be) located – if he has difficulty/pain walking use the wheelchair. * The school nurse or health tech will perform the Specialized Physical Health Care Service of Manual Reduction of Rectal Prolapse within 15 minutes of the prolapse following the SPHCS procedure and MD orders. * Parents are to be notified if student experiences a rectal prolapse at school and reduction is performed. * Scant amount of blood may be present with rectal prolapse, but rectal bleeding is not normal, if present, apply pressure, call parent and if bleeding is a large amount or profuse, call 911. * If rectal prolapse is not easily reduced, have student lie on his side, call parents, if they are not available to get to school within 15 minutes then call 911 for transport to ED for reduction. * Parents and school nurse to be notified of all fieldtrips at least 2 weeks in advance. * Parents are to furnish supplies required for the procedure, i.e., k-y jelly | | | | | | | | | | | |
| **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: | | | | | | | | | | | |
| **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** | | | | | | | | | | | |
| **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** |  |