Health Services Documentation

Dear Parents/Guardians:

It is the goal of District 30 to help each student succeed in school. Some students have health needs that must be taken care of during the school day. Health care services can be provided to eligible students during the school day, so they can learn to their potential. In order to better serve our students, District 30 has created informational forms, which must be completed, if a student requires the development of a health care plan for provision at school. The student's physician must participate in the completion of all requested documentation to ensure that any services delivered by District 30 personnel will appropriately meet the needs of the students with health-related conditions.

We are writing this letter to help you better understand how schools can help students who have special health care needs. Included is information about individual health care plans, Section 504, and the IDEA. The determination of which type of service or plan would best meet the needs of a particular student would be made by a multidisciplinary team inclusive of the student's parents/guardians and the appropriate school personnel. Additional explanatory information about the types of plans that could be considered for a student with a health-related condition is included herein for your information.

Individual Health Care Plans

Individual health care plans are plans that can be written in order to meet the health monitoring and/or care of a specific student during the school day or at school-sponsored functions. The school will develop a team that can work with the student's parents/guardians, health care providers, and teachers to write an individual health care plan that will meet the student's special health care needs. Individual health care plans should be written for students who have health conditions that are medically fragile, require complicated or lengthy health procedures during the school day, who require several contacts with the health assistant during the school day, who have conditions that may require emergency care, or who have been granted permission to self-medicate and/or self-monitor in accordance with the local school board's policy.

Section 504 of the Rehabilitation Act of 1973

Section 504 protects the rights of individuals with disabilities that substantially limit one or more major life activities to take part in programs and services supported by federal funds. Schools that get federal funding must provide a free and appropriate public education in the least restrictive environment to students with physical and mental health impairments that qualify under Section 504. A team of individuals who know about the student's needs determines if a student is eligible for services under Section 504. The team usually includes a parent/legal guardian, the student (if appropriate), a teacher, a principal, the health office staff, and any other relevant school personnel who may be involved in the student's school program. If the student is eligible, the team then develops an individual accommodation plan. The purpose of the individual accommodation plan is to ensure that students with disabilities have educational opportunities equal to those provided to students who do not have disabilities. Section 504 is administered through the United States Department of Education Office for Civil Rights.

Individuals with Disabilities Education Act (IDEA)

The IDEA provides eligible students with disabilities, who are determined to need special education and related services to benefit from their educational programs, the legal right to receive a free and appropriate public education in the least restrictive environment. Students, ages 3 through 21 years, may be eligible for services under the IDEA if they need special education and related services to learn. The school team including the student's parents/legal guardians determines if a student is eligible and identifies the health services, if any, that are necessary to enable the student to attend school and to participate fully and safely in educational activities. The team then develops an individualized education program for the student. A diagnosed illness or special health care need alone will not qualify a student for eligibility under the IDEA.

Medical Homebound Regulations

Medical homebound instruction is a service that may also be available for both disabled and nondisabled students who cannot attend school for a medical reason, even if transportation were furnished. A physician must certify that such a medical condition exists and must complete a medical report indicating the medical reason that the student is not able to attend his/her home school. The Director of Student Services or her designee must then decide whether to approve the student's participation in a program for medical homebound instruction. In making a decision about medical homebound instruction, schools should consider the severity of the student's illness or injury, the length of time that the student will be out of school, the possibility that the student's health care needs might be met at school, and the impact that a long period away from school will have on the student's academic success.

If you think that your child has a special health condition that would require a type of plan in order to provide the services required for your child to be successful at school, you may contact your building principal or the District 30 Director of Student Services.

Medical Conditions and Allergies

Requiring Special Attention

Name of Child _____ School: _____

Describe your child's medical condition: _____

_____

Describe your child's allergy: _____

_____

Does this child have food allergies or dietary restrictions? ☐ Yes ☐ No

If yes, please complete the following:

My child **MAY NOT** eat: _____

My child **MAY NOT** touch: _____

My child may **NOT** be physically near: _____

Please describe the reaction your child may have if he/she consumes or come in contact with the allergen: ___

_____

_____

Please describe the reaction your child may have if he/she comes in contact with the allergen:

_____

_____

My child requires an individual plan for: _____ Life threatening allergies _____ Seizure care

_____ Diabetes management _____ Asthma _____ Other

_____ _____

(Parent Signature) (Date)

_____ _____

Physician Signature (Date)

ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AU

Students

Photograph

Name: _____ DOB: _____
Teacher: _____ Grade: _____
Allergy to: _____
Asthma: ____ Yes (higher risk for a severe reaction ____ N

Weight: lbs.

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, week pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)
SKIN: Many hives over body

Or combination of symptoms from different body areas:

INJECT EPHINEPHRINE IMMEDIATELY

- Call 911
- Begin monitoring (see below)
- Additional medications:
- Antihistamine
- Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis) ⇨ Use Epinephrine.

** When in doubt, use epinephrine. Symptoms

MILD SYMPTOMS ONLY

Mouth: Itchy mouth
Skin: a few hives around mouth/face, mild itch

GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent

__ I**f checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**
__ **If checked, give epinephrine before symptoms if the allergen was definitely eaten.**

MEDICATIONS/DOSES

Injectable Epinephrine (Brand and Dose): _____
Antihistamine (Brand and Dose): _____
Other: (e.g., inhaler, bronchodilator if asthma) _____
___ Student may carry epinephrine ___ Student may self-administer epinephrine

MONITORING: Stay with child. Tell rescue squad epinephrine was given. Second dose of epinephrine can be given a few minutes after the first, if symptoms persist or recur. For a severe reaction, keep child lying on back with legs raised. Treat child

Call 911 **EMERGENCY CONTACTS:**

Parent/Guardian: _____ Phone: (_____)
_____
Name/Relationship:_____ Phone: (_____)
_____
Name/Relationship: _____ Phone: (_____)
_____

Physician Signature: _____ Date:
_____
(Required)

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Government and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Guardian signature: _____ **Date:** _____

INDIVIDUAL EMERGENCY MANAGEMENT PLAN CHECKLIST

(For students at risk for life threatening allergies/conditions)

Student _____ **Date** _____

Teacher _____ Grade _____Room _____

History of emergency care required (include dates, age of child, allergen, symptoms, and treatment):

Prevention strategies: (*Review each item at team meeting and check those that apply*)

Required:

☐ Emergency Care Plan (ECP) and Medication Administration Request form completed and signed by physician

☐ Emergency Response and Care Plans copy given to classroom teacher and placed in sub-folder

☐ Up-to-date Injectable Epinephrin (EpiPen, Twinject, Adenaclick) provided. Number of pens Provided _____

☐ Injectable Epinephrin will be located in:

☐ Health Office ☐ Classroom (elementary schools only) ☐ Outdoor PE (bee sting allergies only)

☐ With student (complete appropriate forms) ☐ Other (please specify) _____

☐ Antihistamine will be provided

☐ Student food allergy information and photo to appropriate staff (specials teachers and lunch supervisors)

☐ To ensure the safety of our students during in-class celebrations, if there are dietary restrictions it will be necessary for the parent(s) to provide alternative foods/treats that are in compliance with the student's health requirements.

☐ Parent awareness of responsibility to inform after-school program supervisors/coaches of Allergy Emergency Care Plan

INDIVIDUAL EMERGENCY MANAGEMENT PLAN CHECKLIST (Continued)

Optional:

- ☐ Peanut Free lunch table
- ☐ Classroom discussion about allergies
- ☐ Preferential seating at end of classroom lunch table with buffer zone
- ☐ Student acquaintance with Health Office
- ☐ Personal student introduction to special area teachers and appropriate staff
- ☐ Use of parent provided Medic Alert bracelet
- ☐ Student photo and allergy information posted in lunchroom, health office and other locations
- ☐ Parent provided classroom birthday treat alternatives (to be stored in the classroom)
- ☐ Parent provided classroom snacks (to be stored in the classroom)
- ☐ Letter to other families informing them of your child's medical condition

Additional Strategies:

EMERGENCY CARE PLAN

(To be completed by Physician)

Student Name: _____ DOB: _____

Allergy to:

_____

Medical Condition:

_____

(See attachment depending on medical condition)

Asthmatic: ___ Yes* ___ No

STEP 1: TREATMENT (circle all applicable areas)

System	Symptom	Give checked medication: (determined by authorizing physician)
* Mouth	Itching and swelling of lips, tongue or mouth	☐ Epinephrine ☐ Antihistamine
* Throat ** Antihistamine	Itching, sense of tightness in the throat, hoarseness, hacking cough	☐ Epinephrine ☐
* Skin	Hives, itchy rash, swelling about the face or extremities	☐ Epinephrine ☐ Antihistamine
*Gut	Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
* Lung ** Antihistamine	Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐
* Heart ** Antihistamine	"Thready" pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐

The severity of symptoms can change rapidly. All above symptoms can potentially progress to a life-threatening situation.

DOSAGE: **Epinephrine:** Inject intramuscularly (circle one)

EpiPen® EpiPen®Jr. Twinject™ 0.3 mg. Twinject™ 0.15 mg.

Antihistamine: give _____

(Medication, dose, route)

Other: give _____

(Medication, dose, route)

* Higher risk for severe reaction

** Potentially life-threatening

EMERGENCY CARE PLAN (Continued)

(To be completed by Physician)

STEP 2: ACTION:

1. Call **911.** State that an allergic reaction has been treated and additional Epinephrine may be needed.
2. Call parents/guardian or emergency contacts.
3. Call Dr. _____ at _____.

DO NOT HESITATE TO ADMINISTER MEDICATION, CALL 911, OR TRANSFER CHILD TO MEDICAL FACILITY EVEN IF PARENTS/GUARDIAN OR DOCTOR CANNOT BE REACHED.

Emergency Contacts:

Name/Relationship	Home Phone	Cell Phone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

This Care Plan has been completed and reviewed by physician, student, parent, and School Health Assistant. The information will be provided to administrators, teachers, and staff to allow for awareness and preparedness in providing the best care for the student.

This Care Plan and emergency medications are to accompany the student on school Field Trips.

Parent/Guardian _____ Date _____

Physician _____ Date _____

School _____
Grade _____

DISTRICT 30 ASTHMA CARE PLAN

Student name _____ Date of Birth _____Male ___
Female ___
Physician's Name _____ Phone _____

Contact Information:
Mother's Name _____ Cell Phone _____
Home Phone _____ Work Phone _____

Father's Name _____ Cell Phone _____
Home Phone _____ Work Phone _____

Emergency Contact Information if parents are unavailable:
Name _____ Relationship to Student _____
Home Phone _____ Cell Phone _____ Work Phone _____

Asthma is: ___ Chronic ___ Activity induced ___ Allergen induced ___ Viral induced

Is the child on asthma prevention medication? ___ Yes ___ No
If yes, what is the medication and dosage? _____

Should any medications be given at school regularly? ___ Yes ___ No
If yes, please complete the following: Medication _____
Dosage _____ _____ Time of administration _____

Does the child carry an inhaler? ___ Yes ___ No
Can the child self-administer the inhaler? ___ Yes ___ No
Should the inhaler be used preventatively prior to exercise regardless of symptoms? ___ Yes ___ No

Is a Peak Flow Meter used? ___ Yes ___ No
If yes, please complete the following: Optimal peak flow range is _____
If peak flow is in the range of _____ **OR** the following symptoms are present:
_____
the Health Office staff should _____

If peak flow is in the range of _____ **OR** the following symptoms are present:
_____
the Health Office staff should _____

_____ _____
Parent Signature Date

_____ _____
Physician Signature Date

DIABETES CARE PLAN

Student Name _____ **School** _____ **Effective Dates** _____

(To be completed by parents/health care team and reviewed with necessary school staff. Copies should be kept in student's classrooms and school records)

Date of Birth _____ **Grade** _____ **Teacher** _____

Contact Information:

Parent/Guardian #1 _____ Address _____

Home Phone _____ __ Work _____ Cell _____

Parent/Guardian #2 _____ Address _____

Home Phone _____ Work _____ Cell _____

Student's Doctor/Health Care Provider _____ Telephone _____

Nurse Educator _____ Telephone _____

Other Emergency Contact _____ Relationship _____

Home Phone _____ Work _____ Cell _____

Notify parent/guardian in the following situations:

_____ _____

_____ _____

Blood Glucose Monitoring

Target range for blood glucose _____ mg/dl to ____ mg/dl type of blood glucose meter student uses: _____

Usual times to test blood glucose:

_____

Times to do extra tests : (check all that apply) ____ Before exercise ____ After exercise

____ When student exhibits symptoms of hyperglycemia ____ When student exhibits symptoms of hypoglycemia

____ Other (explain) _____

Can student perform own blood glucose tests? ___ Yes ___ No Exceptions _____

School personnel trained to monitor blood glucose level and dates of training _____ _____

Insulin

Times, types and dosages of insulin injections to be given during school:

_____

Insulin/carbohydrate ratio _____

Time Type(s) Dosage

_____ _____ _____

_____ _____ _____

Correction Factor _____

For Students with Insulin Pumps:

Type of pump _____

Is student trained regarding pump? ___ Yes ___ No

Can student effectively troubleshoot problems (e.g., ketosis, pump malfunction)?

___ Yes ___ No

Meals and snacks eaten at school (The carbohydrate content of the food is important in maintaining a stable blood glucose level)

Time Food content/amount

Breakfast _____ _____

a.m. snack _____ _____

Lunch _____ _____

p.m. snack _____ _____

A source of glucose, such as _____should be readily available at all times.

Preferred snack foods _____

Snack before exercise? ___ Yes ___ No Foods to avoid, if any

_____

Snack after exercise? ___ Yes ___ No

Instructions for when food is provided to the class (e.g., as part of a party or food sampling

Other times to give snacks and content/amount

_____

Hypoglycemia (Low Blood Sugar) **Hyperglycemia (High Blood Sugar)**

Usual symptoms of hypoglycemia _____ Usual symptoms of hyperglycemia _____

_____

_____

Treatment of hypoglycemia _____ Treatment of hyperglycemia _____ _____

_____

Circumstances when urine or blood ketones should be tested

_____

_____

Treatment for ketones

_____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow:

_____

If required, glucagon should be administered promptly:

_____

and then 911 (or other emergency assistance) and parents should be called.

Exercise and Sports

A snack such as _____ should be readily available at the site of exercise or sports.

Restriction on activity, if any

_____

Student should not exercise if blood glucose is below _____ mg/dl.

Supplies and Personnel

Location of supplies:

Blood Glucose Monitoring equipment: _____

Insulin administration supplies: _____

Glucagon emergency kit: _____

Ketone testing supplies: _____

Snack foods: _____

This Care Plan has been completed and reviewed by physician, student, parent, and School Health Assistant. The information will be provided to administrators, teachers, and staff to allow for awareness and preparedness in providing the best care for the student.

This Care Plan and emergency medications are to accompany the student on school Field Trips.

Signatures

Student's Health Provider _____ Date _____

Parent/Guardian _____ Date _____

School Representative _____ Date _____

Date of Plan: _____

Diabetes Medical Management Plan

This plan should be completed by the student's physician. It should be reviewed with relevant school staff and copies should be kept in a place that is easily accessed by authorized personnel.

Effective Dates: _____

Student's Name: _____

Date of Birth: _____ Date of Diabetes Diagnosis: _____

Grade: _____ Homeroom Teacher: _____

Physical Condition: ☐ Diabetes Type 1 ☐ Diabetes Type II

Contact Information

Mother/Guardian: _____

Address: _____

_____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian: _____

Address: _____

_____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider

Name: _____

Address: _____

_____

Telephone: _____ Emergency Number: _____

Other Emergency Contact

Name: _____

Relationship: _____

Telephone: Home _____ Work _____ Cell _____

Notify parents/guardian or emergency contact in the following situations: _____

_____

_____

Blood Glucose Monitoring

Target range for blood glucose is: ☐ 70-150 ☐70-180 ☐ Other _____

Usual Times to check blood glucose: _____

Times to do extra blood glucose checks *(check all that apply):*

☐ before exercise ☐ after exercise

☐ when student exhibits symptoms of hyperglycemia ☐ when student exhibits symptoms of hypoglycemia

☐ other (explain): _____

Can student perform own blood glucose checks? ☐ Yes ☐ No

Exceptions: _____

_____

Type of blood glucose meter student uses: _____

_____

Insulin

Usual Lunchtime Dose

Base does of Humalog / Novolog / Regular Insulin at lunch (circle type of rapid-short-acting insulin used) is _____ units or does flexible dosing using ____ units/____ grams carbohydrate.

Use of other insulin at lunch: (Circle type of insulin used): intermediate / NPH / lente ____ units or basal / Lantus / Ultralente ____ units.

Insulin Correction Doses

Parental authorization should be obtained before administering a correction dose for high blood glucose levels

☐ Yes ☐ No

_____ units if blood glucose is ____ to ____ mg/dl

_____ units if blood glucose is ____ to ____ mg/dl

_____ units if blood glucose is ____ to ____ mg/dl

_____ units if blood glucose is ____ to ____ mg/dl

_____ units if blood glucose is ____ to ____ mg/dl

Can student give own injections? ☐ Yes ☐ No

Can student determine correct amount of insulin? ☐ Yes ☐ No

Can student draw correct does of insulin? ☐ Yes ☐ No

School staff authorized to adjust the insulin dosage under the following circumstances:

_____

_____

For Students With Insulin Pumps

Type of pump: _____ Basal rates: _____ 12 a.m. to _____

_____ _____ to _____

_____ _____ to _____

Type of insulin in the pump: _____

Type of infusion set: _____

Insulin/carbohydrate ratio: _____ Correction factor: _____

Student Pump Abilities/Skills:	*Needs Assistance:*
Count carbohydrates	☐ Yes ☐ No
Bolus correct amount for carbohydrates consumed	☐ Yes ☐ No
Calculate and administer corrective bolus	☐ Yes ☐ No
Calculate and set basal profiles	☐ Yes ☐ No
Calculate and set temporary basal rate	☐ Yes ☐ No

Disconnect pump ☐ Yes ☐ No

Reconnect pump at infusion set ☐ Yes ☐ No

Prepare reservoir and tubing ☐ Yes ☐ No

Insert infusion set ☐ Yes ☐ No

Troubleshoot alarms and malfunctions ☐ Yes ☐ No

For Students Taking Oral Diabetes Medications

Type of Medication: _____ Timing: _____

Other Medications: _____ Timing: _____

Meals and Snacks Eaten at School

Is student independent in carbohydrate calculations and management? ☐Yes ☐ No

Meal/Snack	*Time*	*Food content/amount*
Breakfast	_____	_____
Mid-morning snack	_____	_____
Lunch	_____	_____
Mid-afternoon snack	_____	_____
Dinner	_____	_____

Snack before exercise? ☐ Yes ☐ No

Snack after exercise? ☐ Yes ☐ No

Other times to give snacks and content/amount: _____

_____

Foods to avoid (if any): _____

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event):

_____

_____

Exercise and Sports

A fast-acting carbohydrate (provided by parents) such as _____should be available at the site of exercise or sports.

Restrictions on activity, if any: _____

Student should not exercise if blood glucose level is below _____ mg/dl or above _____ mg/dl or if moderate to large urine ketones are present.

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia: _____

_____

Treatment of hypoglycemia: _____

_____

Glucagon should be given if the student is unconscious, having a seizure (convulsion), or unable to swallow.

Route: _____ Dosage: _____

Site for glucagon injection: ____ Arm ____ Thigh ____ Other

If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance) and the parent/guardian.

Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia: _____

_____

Treatment of hyperglycemia: _____

_____

Urine should be checked for ketones when blood glucose levels are above _____ mg/dl.

Treatment for ketones: _____

Supplies to be kept at school

_____ Blood glucose meter, blood glucose test strips, batteries for meter

_____ Lancet device, lancets, gloves, etc.

_____ Urine ketone strips

_____ Insulin pump and supplies

_____ Insulin pen, pen needles, insulin cartridges

_____ Fact-acting source of glucose

_____ Carbohydrate containing snack

_____ Glucagon emergency kit

Signatures

This Diabetes Medical Management Plan has been approved by:

_____ _____

Student's Physician/Health Care Provider Date

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____ School to perform and carry out the diabetes care tasks as outlined by _____'s Diabetes medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

This Care Plan has been completed and reviewed by physician, student, parent, and School Health Assistant. The information will be provided to administrators, teachers, and staff to allow for awareness and preparedness in providing the best care for the student.

This Care Plan and emergency medications are to accompany the student on school Field Trips.

Acknowledged and received by:

_____ _____

Student's Parent/Guardian Date

_____ _____

Student's Parent/Guardian Date

INDIVIDUALIZED SCHOOL HEALTH CARE PLAN FOR A

STUDENT WITH A PACEMAKER OR IMPLANTED DEFRIBRILLATOR (ICD)

Name of Student: _____ DOB: _____ School Year: _____

School: _____ Grade Level teacher: _____ Grade: _____

Medical Diagnosis/Chronic Health Condition: Both ICDs and pacemakers are devices that are implanted under the skin and connected to wires or leads that are placed in the heart. Both continuously monitor the heart to detect changes in its natural rhythm. A pacemaker is used to detect a heart rate that is too slow (bradycardia). When it senses a rhythm that is too slow, it sends an electrical signal to stimulate or pace the heart so it continues its normal electrical beat. This electrical signal is strong enough to stimulate the heart to beat, but not strong enough for the student to feel. An ICD, on the other hand, detects a too-rapid or chaotic heartbeat and delivers a stronger lifesaving electrical shock to restore the heart to its natural rhythm. Some ICDs also act as pacemakers. Sudden cardiac death (SCD) is the result of an "electrical problem" in the heart, causing the heart to stop pumping blood to the brain and vital organs. A student with a known risk of SCD is sometimes treated with medication, usually with beta-blockers. Sometimes an ICD is implanted to provide extra protection. Whenever someone becomes suddenly unresponsive, a sudden cardiac arrest should be suspected and rapid response with effective CPR and use of an AED is needed. (This would also be true if a student has an ICD, and becomes unresponsive.)

Special considerations and Precautions: There are some general things to know about that will apply to most students:

1. After surgery, discharge from the hospital is usually within 1-2 days. There may be some pain over the incision for 1-2 weeks. Instructions may be given to avoid raising the arm over the shoulder on the side of the implantation for several weeks. Contact sports, vigorous exercise (especially involving above the shoulder movements) and lifting over 5 pounds are also usually restricted for several weeks. There may be a need for two sets of books, a set each for school and home. Post-operative concerns requiring parental and/or physician supervision include: bleeding from the incision, increased pain over the incision, fever, swelling or discharge from the incision site, swelling of the arm on the side of the implantation, twitching of chest muscles, persistent hiccups, dizziness, fainting, chest pain or shortness of breath.

2. After initial recovery, most students can resume normal activities. The physician should prescribe any specific ongoing activity restrictions for each student. There will likely be PE and sports restrictions.

3. ICDs are well protected from most household electrical appliances in good condition, such as radios, televisions, stereos, microwaves, computers, etc. Cellular phones may interfere with ICDs, but can usually be held in the hand opposing the implant, and should not be kept in a chest pocket. The same precautions apply to carrying an MP3 player. Metal or theft detector gates can generate signals that interfere with the ICD. Walking through the gate should not cause a problem, but standing near the gate for extended periods of time should be avoided. Handheld metal detectors should not be used for more than 30 seconds over the chest area, or a hand search should be substituted. Students should stand at

least two feet from welding equipment, high-voltage transformers or motor generating systems. This may be a consideration in Industrial Arts classes.

Physician Name: _____ **Phone Number:** _____

Emergency Contacts:

Parent/Guardian	Relationship	Phone Number	Alternate phone/contact method (including e-mail)

Daily Medications:

Drug Name	Dose	When/how to use	Side effects to observe for

Medications in case of emergency: _____
(Will be provided to the school health office by parents in its original container with prescription dosage information listed)

Special considerations and precautions:

_____

_____

_____

Activity/PE restrictions/Recess participation: Self-limiting physical exercise may be allowed, however this varies from child to child. Competitive sports in many cases will be prohibited.

_____

_____

_____

For field trips

On field trips and other activities away from school, an AED and a trained CPR responder should be available. An emergency communication devise, such as a cell phone, should always be available.

Emergency Plan

The student will usually feel nothing when the pacemaker is stimulated.

A shock from an ICD may feel like a sudden painful kick in the chest. It occurs in an instant, than is gone. If the student becomes unresponsive first, the shock may not be felt. If the student receives a shock from the device and recovery is immediate, the family should be notified and directions for calling the device clinic should be followed. If one or more shocks occur without rapid recovery, emergency services should be called. If CPR and AED therapy are needed, they should be started immediately. Remember to place the AED pad at least an inch away from the implanted unit.

Other accommodations:

_____

_____

_____

I, this child's parent/guardian, hereby authorize the physician who has attended my child to furnish to the School Health Services of School Clinic staff any medical information and/or copies of records pertaining to my child's chronic health condition, and for this information to be shared with pertinent school staff. I understand that HIPAA regulations limit disclosure of certain medical information. However, I expressly authorize disclosure of information so that my child's medical needs may be served while at school. This authorization expires as of the last day of school of this school year.

Parent/Guardian Signature: _____ **Date:** _____

SEIZURE CARE PLAN

Student Name _____ Birth date _____ ☐ Male ☐ Female

School _____ Grade _____

Physician's Name _____ Phone _____

Seizure Emergency Contact #1 Name _____ Relationship _____

Phone _____ Phone _____

Seizure Emergency Contact #2 Name _____ Relationship _____

Phone _____ Phone _____

For Emergency Transport Call 911

Type of Seizure Disorder _____

Date of Diagnosis _____ Date of last seizure _____

Recent History	When	Activity/Event/Trigger
Seizure at home		
Seizure at school		
Need for emergency medications		

Daily Maintenance Seizure Medications

Medication	Where?	When?
	Home ☐ School ☐	AM ☐ Noon ☐ PM ☐
	Home ☐ School ☐	AM ☐ Noon ☐ PM ☐
	Home ☐ School ☐	AM ☐ Noon ☐ PM ☐

Emergency School Seizure Medications

Medication	Where is it kept?	When to use?
	Health Office ☐ With student ☐	
	Health Office ☐ With student ☐	
	Health Office ☐ With student ☐	

Typical Seizure *(circle those that apply)*

Type of Seizure	Description
Absence (Petit Mal)	Mild form of seizure, dizziness or staring into space
Tonic-Clonic (Grand Mal)	Seizure with severe convulsions & loss of consciousness
Myoclonic	Spasms limited to 1 side of body or 1 muscle group
Atonic (drop attacks)	Produce head drops, loss of posture, or sudden collapse
Simple Partial Seizure	Electrical disturbance, remains conscious

Complex Partial Seizure	Electrical disturbance, consciousness loss or impaired

Other type of seizure to your child: _____

_____

Behavior Changes related to Seizures (before/during/after) *(circle those that apply)*

Abnormal body movements	Sudden weakness/falling	Odd facial expressions
Odd eye rolling/staring	Mouth movements/chewing	Lip smacking/sucking
Repeating words/sounds	Arms jerk/drop/throw	Weakness of arms/legs
Hand movements/fumbling	Abnormal perception	No response to voice/touch
Odd sensory experiences	Sweating	Change in heart rate
Flushed skin tone	Pale skin tone	Drooling
Hallucinations	Sensitive to light/sound	Emotional changes

Do any of the above behaviors typically occur prior to the onset of a seizure:

_____

Special instructions if observed:

_____

Behaviors specific to your child: _____

_____

Describe YOUR CHILD'S typical seizure: _____

_____

_____

Seizure First Aid for Tonic/Clonic Seizure:

1) Keep calm. Keep/put students in a reclining or side-lying position and allow seizure to run its course.
2) Push away near-by objects.
3) Call for help. Use phone or walkie-talkie to contact health assistant.
4) Have someone escort other students to alternate location.
5) Do not force a blunt object between teeth.
6) Do not restrain student.
7) If seizure lasts beyond 5 minutes or if seizures occur consecutively – **CALL 911**
8) **CALL PARENT**

Post Seizure Care (for seizures lasting less than 5 minutes) Underline all that apply:

1) When the muscle jerking has stopped:
    a. Turn student onto his/her side
    b. Maintain an open airway
    c. Give artificial respiration if breathing stops and **CALL 911**
    d. Do not give any fluids if unconscious or partially conscious
2) After the seizure, allow student to sleep or rest for _____ (amount of time) and **NOTIFY PARENTS.**

Special Instructions: _____

_____

This Care Plan has been completed and reviewed by physician, parent, and School Health Assistant. The information will be provided to administrators, teachers, and staff to allow for awareness and preparedness in providing the best care for the student.

This Care Plan and emergency medications are to accompany the student on school Field Trips.

Physician Signature _____ Date _____

Parent Signature _____ Date _____

District Representative Signature _____ Date _____