Cerebral Shunt Individual Health Care Plan

School year

Student legal last name | First name | MI

Birth date | School | Grade | Other ID

Transportation: ☐ Walker ☐ Self Transported ☐ Bus Rider Bus Route Number

Parent/Guardian Information

Parent/Guardian | Primary phone - -

Work phone - - | Cell phone - -

Parent/Guardian | Primary phone - -

Work phone - - | Cell phone - -

Healthcare Provider and Hospital Information

Healthcare Provider Name | Phone - -

Preferred Hospital | Phone - -

Health Concern

Location/Side of Shunt ☐ Left ☐ Right

Current Medications

Rescue and Maintenance

Health History

Special Precautions/ Instructions

PE Activity Guidelines

Medication Orders

Medication Name | Dose | When

No medication(s) at school needed.

- - | - -

Healthcare Provider's Name *(Printed)* | Phone | Fax

Healthcare Provider's Signature | *Date*

Emergency Intervention Plan

Mild Symptoms	Immediate Response
Headache, Decreased activity, Personality changes, Decreased school performance, confusion or memory problems, Elevation in temperature, Lapses in attention, Changes in vision	Contact Parent and School Nurse See Healthcare Provider right away

Additional student information

Moderate Symptoms	Immediate Response
Vomiting, Sleepier than usual, More irritable than usual, Headache behind the eyes that does not go away, Lethargy	Contact Parent and School Nurse See Healthcare Provider right away If symptoms are bordering on severe or if there is any doubt, **CALL 911**

Additional student information

Severe Symptoms	Immediate Response
Difficult to wake up, Pain or headache down neck, Pupils react to light by may be sluggish, Constant vomiting	**CALL 911**

Additional student information

Critical Symptoms	Immediate Response
Unresponsive, Dilated pupils, Irregular breathing, Changes in blood pressure or heart rate	**CALL 911**

Emergency Contacts

Name Phone - - Relationship

Name Phone - - Relationship

Name Phone - - Relationship

I give Health Services staff permission to communicate with the healthcare provider office about this medication.

I understand the medication(s) will be given by school nurse or trained designated staff.

Medical/Medication information may be shared with school staff working with my child and 911 staff if they are called.

Parent/Guardian Signature ____________________ Date __________

School Nurse Signature ____________________ Date __________

Healthcare Provider's Signature ____________________ Date __________

A copy of this plan will be kept in the school health room and the information will be shared with others who will need to know to maintain the child's health and safety.

CONFIDENTIAL INFORMATION/SHRED PRIOR TO DISCARDING