



How to Write an IHP

A delightful presentation by:

Cindy Vandenberg, RN
Kimberly Area School Nurse

Why Do We Do This Crazy Thing?

- ▶ It is written for you... it documents that you are providing the needed care for a student.
- ▶ It is written for school teachers and paraprofessionals... they know what the health expectations are for this student. “Who is doing what?!?”
- ▶ Most of all it is written for the student... it assures them the care needed to successfully participate and be available for learning in school.

First Things First

- ▶ You are notified of a new or transferring student who has a special health need.
- ▶ Start by getting the contact information and calling the parents.
- ▶ Better to meet with the parents and student in person if possible.

Case Study

- ▶ 7 year old 2nd grade student. Male.
- ▶ Born with sacralcoccygeal teratoma (spinal tumor) and had surgery to remove it.
- ▶ “Lots of care issues....” according to school staff.

Decisions, Decisions, Decisions...

- ▶ Use the *Nursing Process!*
- ▶ We need to *Assess (Step 1)*... collect subjective data through interview with parents and student to determine what the health conditions are and what are their main areas of concern.
- ▶ Collect objective data through physical assessment of the student.

Interview with Parent and Student

- ▶ Joe Student was born with a sacralcoccygeal teratoma.
- ▶ The tumor resulted in limited growth/function of his lower legs, crowding of the lungs during development, gastrointestinal malformations and genitourinary malformations. Upper limbs are within normal limits.
- ▶ Small stature (about 30 pounds)
- ▶ He is able to independently get around in his wheel chair. Needs assistance with some ADL's but mom wants him to do as much for himself as possible.
- ▶ Student has a **vesicostomy** (An opening in the abdomen that allows urine to drain continuously from the bladder) **and colostomy** (A surgical procedure that brings one end of the large intestine out through the abdominal wall. Stools moving through the intestine drain into a bag attached to the abdomen.).

Interview with Parent and Student

- ▶ Requires intermittent clean urinary catheterization twice during the school day
- ▶ Requires PRN colostomy bag emptying/burping and changes.
- ▶ Has reduced lung size requiring PRN inhaler use
- ▶ Absence seizures
- ▶ Latex allergy
- ▶ Blood glucose fluctuations
- ▶ Kidney failure.
- ▶ Has special dietary needs due to kidney failure: needs to receive a low potassium, low sodium diet.

Diagnosis (Step 2)

- ▶ Review data collected and determine the Nursing Diagnoses which are best suited to your students needs.

Resources

- ▶ The “big purple book” - *Individualized Healthcare Plans for the School Nurse*
- ▶ The “gray book” - *School Nursing and Health Services*
- ▶ The Internet.
- ▶ Friends and Colleagues.

Which Nursing Diagnoses Would You Select?

Health Information

- ▶ Joe Student had sacralcoccygeal teratoma in utero.
- ▶ He had surgery to remove the tumor resulting in limited growth / function of lower limbs. Upper limbs within normal limits.
- ▶ Small stature (about 30 pounds)
- ▶ He is able to independently get around in his wheel chair. Needs assistance with some ADL's but mom wants him to do as much for himself as possible.
- ▶ Student has a vesicostomy and colostomy.
- ▶ Requires intermittent clean urinary catheterization twice during the school day
- ▶ Requires PRN colostomy bag emptying/burping and changes.
- ▶ Has reduced lung size requiring PRN inhaler use
- ▶ Absence seizures
- ▶ Latex allergy
- ▶ Blood glucose fluctuations
- ▶ Kidney failure.
- ▶ Has special dietary needs due to kidney failure: needs to receive a low potassium, low sodium diet.

What We Selected

- ▶ Impaired physical mobility related to lower limb underdevelopment
- ▶ Risk for injury related to lower limb underdevelopment / weakness / immobility
- ▶ Disturbed sensory perception related to seizure condition
- ▶ Risk for impaired skin integrity related to immobility and leakage of body fluids
- ▶ Self-care deficit in dressing and toileting related to physical disability
- ▶ Alteration in urinary elimination pattern related to neuromuscular impairment
- ▶ Alteration in bowel elimination pattern related to surgical intervention (colostomy)

Planning (Step 3)

- ▶ It is time to *Plan...* what procedures need to be done, who will do the procedures, can they be delegated or not, what do I need doctor orders for, what do I need emergency procedures for?

Let's Do It!

- ▶ We have selected our Nursing Diagnosis using our resources.
- ▶ In developing the IHP, we need to now look at the Goals, Interventions and Outcomes and choose which are most appropriate for the student.
- ▶ Let's develop the plan!

What Plans, Procedures, Orders, Consents and Competencies Do You Need?

Health Information

- ▶ Joe Student had sacralcoccygeal teratoma in utero.
- ▶ He had surgery to remove the tumor resulting in limited growth / function of lower limbs. Upper limbs within normal limits.
- ▶ Small stature (about 30 pounds)
- ▶ He is able to independently get around in his wheel chair. Needs assistance with some ADL's but mom wants him to do as much for himself as possible.
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- ▶ Kidney failure.
- ▶ Has special dietary needs due to kidney failure: needs to receive a low potassium, low sodium diet.

What We Put Together

- ▶ Procedures for clean catheterization and colostomy care.
- ▶ Orders from the doctor to do procedure (MD signature).
- ▶ Competency for training UAP on clean catheterization and colostomy care.
- ▶ Emergency evacuation plan.
- ▶ Emergency plan for asthma, seizures, blood glucose monitoring, latex allergy.
- ▶ Dietary order for low potassium, low sodium diet.
- ▶ Medication consent for asthma inhaler (MD signature).

<i>Date</i>	<i>Nursing Diagnosis</i>	<i>Goals</i>	<i>Interventions</i>	<i>Outcome</i>
8-25-14	N.D. 1 Impaired physical mobility related to lower limb underdevelopment (sacralcoccygeal teratoma).	<p>Student will be independent with mobility in the school setting.</p> <p>Increase independence with mobility in the school setting.</p> <p>Develop and implement an emergency evacuation plan.</p>	<p>Orient student to the school building, make note of rooms or areas that are inaccessible, such as the media center, band room, auditorium, etc., and modifications that need to be made to make them accessible.</p> <p>With the student, check all classrooms to make sure there are desks or tables that will accommodate the student's needs, such as the wheelchair being able to fit under the desks or tables.</p> <p>Educate teachers and para-professionals on assistive measures that will be needed in the classroom, such as accessing books and materials that are needed, assistance with writing for assignments and tests, assistance with completing special assignments or experiments, etc., based on student need and preference.</p> <p>Develop an EEP that clearly indicates how the student will be evacuated from the building in case of an emergency situation. All persons who will be involved with the student during the school day, as well as the student, should be involved in developing and practicing the plan.</p> <p>With the student, check the time it takes to get from class to class, class to lunch, and last class to bus home, and make modification in release times if needed.</p> <p>Assist the student to maintain proper body positioning in his/her wheelchair.</p>	<p>The student will demonstrate independent mobility in the school setting.</p> <p>The student will utilize adaptive devices to increase mobility in the school setting.</p> <p>The student will assist to develop and implement an EEP.</p>

<p>8-25-14</p>	<p>N.D. 2 Risk for injury related to lower limb underdevelopment/ weakness/ immobility</p>	<p>The student will assist in the prevention of physical injuries.</p>	<p>Monitor environment for possible contact with environmental hazards, such as chemicals, heat/cold, slippery floor or sidewalk surfaces, etc. Utilize measures to prevent exposure.</p> <p>Assist the student to maintain proper body positioning in his/her wheelchair.</p> <p>Discuss with the student factors that increase risk of injury.</p> <p>Instruct student to use safety equipment, properly, at all times, such as having the wheelchair belt securely fastened. Monitor use.</p> <p>Utilize correct techniques for moving, transferring, and transporting the student.</p> <p>Handle extremities carefully when turning and positioning.</p>	<p>The student will maintain proper body positioning in wheelchair (percent of time).</p> <p>The student will identify factors that increase the risk of injury</p> <p>The student will utilize safety measures to prevent injury (specific measure).</p> <p>The student will propel wheelchair safely in the school environment and on field trips.</p>
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8-25-14	N.D. 3 Disturbed sensory perception related to seizure condition	<p>The student will (as developmentally able) communicate effectively with others.</p> <p>The student will wear medical alert jewelry</p>	<p>Provide student-specific information to selected school personnel for student:</p> <ul style="list-style-type: none">- Type of seizure, treatment regimen- Precautions, safety issues- First aid care for immediate and recovery care- Emergency plan of care and follow-up- Evacuation plan <p>Encourage student to wear medical alert jewelry at all times.</p>	<p>Student will verbalize age-appropriate acceptance of seizure disorder.</p> <p>Student will wear a medical alert bracelet.</p>
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8-25-14	N.D. 4 Risk for impaired skin integrity related to immobility and leakage of body fluids.	Utilize prevention methods to prevent skin breakdown and pressure areas.	<p>Assist the student to maintain proper body positioning in his/her wheelchair.</p> <p>Discuss with student:</p> <ul style="list-style-type: none"> - what skin breakdowns are - ways to prevent skin breakdown and pressure areas, such as shifting weight at least once every class period - signs and symptoms of skin breakdown - what to do if signs and symptoms are present <p>Assist student to notify parent(s) if signs or symptoms of a skin breakdown or pressure area occur.</p> <p>Assist the student to keep skin and clothing clean and dry.</p> <p>Inspect skin for signs and symptoms of skin breakdown, especially when doing catheterization procedures, when cleaning or changing colostomy, or changing the student's clothing</p>	<p>The student will maintain proper body positioning in wheelchair (percent of time).</p> <p>The student will identify causes of skin breakdown and pressure areas.</p> <p>The student will identify prevention methods that can be used to prevent skin breakdown.</p>
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<p>8-25-14</p>	<p>N.D. 5 Self-care deficit in feeding, dressing/grooming, toileting, related to physical disability.</p>	<p>Student will participate verbally and physically in: feeding, dressing and toileting.</p> <p>The student will increase self-care skills in feeding, dressing and toileting.</p> <p>The student will maintain optimal hygiene, with assistance as needed.</p> <p>The student will make decisions regarding health management, assistive care, school and peer activities.</p>	<p>With the student and parents, determine areas for potential increase in participation in self-care activities.</p> <p>Provide opportunities for the student to increase his/her self-care skills, such as choosing which clothes to wear, getting his/her own drink of water, opening his/her own locker after it has been unlocked by a peer or adult, etc.</p> <p>During care activities, provide choices and request preferences from the student.</p> <p>Assist the student to ask for and accept assistance from others when it is appropriate.</p> <p>Encourage good hygiene, grooming, and dress.</p> <p>Emphasize the student's strengths and abilities.</p>	<p>The student will demonstrate active participation in feeding, hygiene, toileting, and dressing and grooming activities.</p> <p>The student will make choices and request preferences with caregivers, as observed by school personnel and parent(s).</p> <p>The student will demonstrate increase in self-care skill (specific increase, specific skill).</p> <p>The student will demonstrate good hygiene and appearance in school, with assistance as requested or needed.</p> <p>The student will ask for and accept assistance, when needed.</p>
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<p>8-25-14</p>	<p>N.D. 6 Alteration in urinary elimination pattern related to neuromuscular impairment.</p>	<p>Prevent leaking of urine during the school day.</p> <p>Prevent infections. Maintain adequate dietary and fluid intake.</p>	<p>Obtain medical orders for vesicostomy catheterization in the school setting.</p> <p>If delegated, train, observe and supervise staff.</p> <p>The student is able to self-catheterize with assistance. Provide a private area that is handicap-accessible and easily accessible for the student. Provide a place for the student to store catheters and other supplies.</p> <p>Inform the student's teachers of the student's need for catheterization and, if needed, extra time out of class for the procedure to be done.</p> <p>Assist student to have and store extra clothing and supplies in school in case urinary leaking occurs.</p> <p>Encourage the student to maintain adequate fluid intake.</p> <p>Monitor for signs and symptoms of an infection.</p> <p>Discuss with the student:</p> <ul style="list-style-type: none"> - signs and symptoms of a bladder infection - what to do if the signs and symptoms occur <p>Assist the student to notify his/her parent(s) if any signs or symptoms of a urinary tract infection occur.</p>	<p>Identify the signs and symptoms of a bladder infection.</p> <p>The student will describe what to do if signs and symptoms of a bladder infection occur.</p> <p>The student will self-catheterize every 4 to 6 hours.</p> <p>The student will participate in catheterization plan.</p> <p>The student will experience no urinary leaking during the school day.</p> <p>The student will accurately report signs and symptoms of a bladder infection to his/her parent(s).</p> <p>The student will demonstrate adequate fluid intake, as observed by parent(s) and reported by student.</p>
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Special Procedures Order



Kimberly Area School District

HEALTH SERVICES

Cindy Vandenberg, School Nurse
 Kathy Verstegen, School Nurse
 Wendy Van Nuland, School Nurse

PO Box 159, Combined Locks, WI 54113

Phone (920) 788-7900 Fax (920) 788-7919

August 2014

Student:

Birthdate:

Dear Doctor:

The parent or guardian of the student listed above has requested that a specialized physical healthcare procedure be performed at school (see attached). Please complete the "Physician's Order" on the back of this form as soon as possible and return to the school address above.

Please notify the school immediately if the order for the procedure(s) changes or if you are no longer treating this pupil. For your convenience, a sample copy of the procedure has been attached for your review.

Thank you for your prompt attention to this matter. Please be advised that the service cannot be provided until your orders have been received.

Cindy Vandenberg, RN
 School Nurse
 Kimberly Area School District

Physician's Order

Name of Student		Birthdate	
Street Name	City	State	Zip

I, the undersigned, as the physician for the above-named student, do recommend and approve the following procedure(s) to be provided to this pupil during school hours:

- Name and description of procedure(s):
- The physical condition(s) of this pupil is (are):
- The procedure(s) is (are) to be provided according to the following time schedule or PRN (as necessary):
- Please check one item and sign the attached procedure:
 - I have reviewed and approved the attached procedure as written
 - I have reviewed and approved the attached procedure with my modifications, which I have noted.
 - I have attached my recommendations or orders for the procedure.
- List any specifications for the procedure:
- Please list any signs or symptoms that may indicate an emergency situation. List the emergency procedures.
- List any concerns about transporting the student on the school bus.

Physician's Name <i>Type or Print</i>		Phone Area/Number	
Physician's Signature		Date Signed	
Street Address	City	State	Zip

Catheterization Procedure

Joe Student
Clean Intermittent Catheterization Procedure
School Year 2014-2015

Clean Catheterization to be performed twice daily by trained staff at Great School in AM and PM.

Supplies

Sterile disposable urinary catheter
Clean latex-free gloves
Sink with soap
K-Y Jelly
Urinal
2X2 gauze

Procedure

1. Gather needed supplies (K-Y Jelly, catheter, gloves, 2X2)
2. Wash hands.
3. Apply gloves.
4. Place small amount of lubricant on 2X2
5. Coat proximal end of catheter in lubricant (remember to keep this end of the catheter clean at all times)
6. Place distal end of catheter in urine container
7. Give student the catheter so he can self-catheterize
8. Drain into urinal until flow stops.
9. Remove catheter.
10. Empty urine into toilet and flush.
11. Rinse urinal and return to supplies.
12. Throw away catheter.
13. Wash hands.

Competency

Kimberly Area School District Health Services
Competency Checklist: Vesicostomy Catheterization

Steps	Training date/ Trainer initials	Demonstration date/ Trainer Initials
1. Gather needed supplies (K-Y Jelly, catheter, gloves, 2X2)		
2. Wash hands.		
3. Apply gloves.		
4. Place small amount of lubricant on 2X2		
5. Coat proximal end of catheter in lubricant (remember to keep this end of the catheter clean at all times)		
6. Place distal end of catheter in urine container		
7. Give student the catheter so he can self-catheterize		
8. Drain into urinal until flow stops.		
9. Remove catheter.		
10. Empty urine into toilet and flush.		
11. Rinse urinal and return to supplies.		
12. Throw away catheter.		
13. Wash hands.		

Employee Name: _____ Employee Signature: _____

School _____ Trainer Signature: _____

Trainer Signature: _____ Trainer Signaure: _____

Principal Signature: _____

Ostomy Procedure

Joe Student
Ostomy Care
School Year 2014-2015

Routinely check Joe's ostomy bag during the school day. If inflated with air, vent bag using universal precautions.

If ostomy bag is leaking, a new one will need to be applied per the following procedure.

Supplies

Adhesive remover
Skin prep pads
Ostomy seal and bags
Paper tape
Gloves
Heated wipes
Clavicide

Procedure

1. Assemble supplies and warm water/wipes
2. Assist student to lay on a clean mat or health cot
3. Remove soiled bag and clothing and double bag these items
4. Cleanse skin with warm soapy water/wipes
5. Allow skin to dry thoroughly
6. Cleanse residual skin prep solution off with adhesive remover
7. Prep skin around ostomy with skin prep swab
8. Tear small 1-7/8 inch seal in half (save 1/2 in baggie for future use), if available
9. Form half of the seal into a circle and apply tightly around the stoma
10. With bigger seal, manipulate circle opening so that it is just big enough to fit around stoma
11. Apply ostomy bag to seal and ensure a tight, wrinkle free fit
12. Remove protective paper from underside of seal
13. Apply seal to skin avoiding wrinkles
14. Set heated wipes on top of colostomy bag for two minutes to help activate seal
15. Remove gloves
16. Wash hands
17. Cleanse mat/cot with clavicide

Competency

Kimberly Area School District Health Services
Competency Checklist: Colostomy Bag Change

Steps	Training date/ Trainer initials	Demonstration date/ Trainer Initials
1. Gather supplies and warm water wipes: Adhesive remover, Skin prep pads, Ostomy seal and bags, Paper tape, Gloves, Heated wipes, Cavicide		
2. Assist student to lay on a clean mat or health cot		
3. Remove soiled bag and clothing and double bag these items		
4. Cleanse skin with warm soapy water/wipes		
5. Allow skin to dry thoroughly		
6. Cleanse residual skin prep solution off with adhesive remover		
7. Prep skin around ostomy with skin prep swab		
8. Tear small 1-7/8 inch seal in half (save 1/2 in baggie for future use), if available		
a. Form half of the seal into a circle and apply tightly around the stoma		
b. With bigger seal, manipulate circle opening so that it is just big enough to fit around stoma		
9. Apply ostomy bag to seal and ensure a tight, wrinkle free fit		
10. Remove protective paper from underside of seal		
11. Apply seal to skin avoiding wrinkles		
12. Set heated wipes on top of colostomy bag for two minutes to help activate seal		
13. Remove gloves		
14. Wash hands		

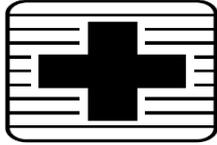
Employee Name: _____ Employee Signature: _____

School _____ Trainer Signature: _____

Trainer Signature: _____ Trainer Signaure: _____

Principal Signature: _____

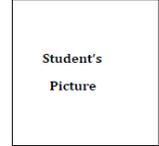
Emergency Evacuation Plan



Kimberly Area School District

Health Services

Cindy Vandenberg, School Nurse 423-4144
 Kathy Versteegen, School Nurse 423-4147
 Wendy Van Nuland, School Nurse 423-4150



PO Box 159 Combined Locks, WI 54113

Fax (920) 788-7919

Student's Name: Joe Student	DOB:	Date: Sept 2014
School Attending: Great School	Grade: 2	Bus Student: Yes No
Health Condition: History of Spinal Tumor / Limited Use of Lower Extremities		
Special Instructions: See attached Individualized Health Plan (IHP).		
<p style="text-align: center;">Emergency Evacuation Plan</p> <p>Concern: Joe is physically impaired and would have difficulty evacuating the building in an emergency situation. He uses manual wheelchair (dependent on others) for mobility around school or is carried by school staff.</p> <p>Plan: Great School is on one level therefore there are no stairs to negotiate. General procedures should be followed as laid out in the KASD Fire and Tornado emergency plans. The classroom teacher in the student's classroom will be responsible for carrying/wheeling the student outdoors or into the hallway as appropriate.</p>		
I have reviewed the health plan for my child: (Choose One)		
The plan is correct as written _____ The plan is correct with the changes noted above _____		
Student health information is shared via email, copies of health plans and/or staff meetings with grade level teachers, coaches, bus company and office staff.		
Elementary/Intermediate Students ONLY: Yes _____ No _____ I would also like ALL school staff to be aware of my child's health condition via powerpoint presentation at an ALL school staff inservice		
Parent's Signature:	Date:	

Asthma Emergency Plan

Daily Management Plan:
Identify the things which start a breathing emergency (Check each that applies to the student.)

<input type="checkbox"/> Exercise	<input type="checkbox"/> Strong odors or fumes	<input type="checkbox"/> Other _____
<input type="checkbox"/> Respiratory infections	<input type="checkbox"/> Chalk dust / dust	_____
<input type="checkbox"/> Changes in temperature	<input type="checkbox"/> Carpets in the room	_____
<input type="checkbox"/> Animals	<input type="checkbox"/> Pollens	_____
<input type="checkbox"/> Food _____	<input type="checkbox"/> Molds	_____

Control of School Environment:
List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an emergency episode:

Peak Flow Monitoring: Student has peak flow meter: Yes No Personal Best Peak Flow number: _____

Daily Medication Plan:

Name	Amount	When to use
1. _____	_____	_____
2. _____	_____	_____

FOR COMPLETION BY PHYSICIAN: Physician's Name: _____ Phone: _____

Diagnosis: _____

Name of Medicine: _____

Form: _____	Dosage: _____
Is the child knowledgeable about his or her medication: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the child demonstrated the proper technique in administering medication: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicine is administered daily: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, time: _____
Medicine is administered when needed. Indications: _____	
If needed, how soon can administration of medicine be repeated? _____	The medication cannot be repeated more than: _____
Side effects: _____	
<input type="checkbox"/> I have instructed _____ in the proper way to use his/her inhaled medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.	
<input type="checkbox"/> It is my professional opinion that _____ should not carry and use his/her inhaled medication by him/herself.	

Physician's Signature: _____ Date: _____

FOR COMPLETION BY PARENT: Is the child authorized to carry and self-administer inhaled medications: Yes No

Medication Consent: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication. I further agree to hold the Kimberly Area School District, and the KASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary.

If self-medication is allowed or if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by my physician and myself. I understand, as the parent, I am responsible to assure that backup/rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events.

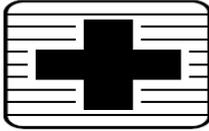
I have reviewed the health plan for my child. The plan is correct as written The plan is correct with the changes noted above

Student health information is shared via email, copies of health plans and/or staff meetings with grade level teachers, coaches, bus company and office staff
Elementary/Intermediate Students ONLY: Yes No I would also like ALL school staff to be aware of my child's health condition via powerpoint presentation at an ALL school staff in-service

Parent's Signature: _____ Date: _____ Rev. 5/2014, blue

Principal Initials: _____

Seizure Emergency Plan



Kimberly Area School District Health Services

Cindy Vandenberg, School Nurse 423-4144
Kathy Versteegen, School Nurse 423-4147
Wendy Van Nuland, School Nurse 423-4150

Student's
Picture

PO Box 159 Combined Locks, WI 54113

Fax (920) 788-7919

Student's Name:		DOB:	Date:
School Attending:		Grade:	Bus Student: Yes No
Health Condition: Seizure – Emergency Care			
Seizure Type	Length	Frequency	Description
Seizure triggers or warning signs:			
Student's response after a seizure:			
Basic Seizure First Aid <ul style="list-style-type: none"> Stay calm and track time Keep child safe Do not restrain Do not put anything in mouth Stay with child until fully conscious Record seizure in log For tonic-clonic seizure: <ul style="list-style-type: none"> Protect head Keep airway open/watch breathing Turn child on side 		A Seizure is Generally Considered an Emergency When <ul style="list-style-type: none"> Convulsive (tonic-clonic) seizure lasts longer than 5 minutes Student has repeated seizures without regaining consciousness Student is injured or has diabetes Student has a first-time seizure Student has breathing difficulties Student has a seizure in water Call ambulance if <ul style="list-style-type: none"> Diastat is given. Seizure lasts longer than 5 minutes or seizure lasts less than 5 minutes and is followed by another seizure. Parent or emergency contact can not be reached 	
A "seizure emergency" for this student is defined as:			
Emergency Medication	Dosage	Common Side Effects & Special Instructions	
Has Emergency Medication ever been administered? Yes _____ No _____ If YES, date of last dose: _____			
Medication Consent: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication. I further agree to hold the Kimberly Area School District, and the KASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary.			
I have reviewed the health plan for my child. (Please choose below) _____ The plan is correct as written. _____ The plan is correct with the changes noted above.			
Student health information/plans are shared via email, copies and/or staff meetings with grade level teachers, coaches, bus co. and office staff.			
Elementary/Intermediate Students ONLY: Yes _____ No _____ I would also like ALL school staff to be aware of my child's health condition via powerpoint presentation at an ALL school staff inservice.			
Parent's Signature:		Date:	
Physician's Signature:		Date:	
		Revised 05/2014	
Principal's Initials:			

Blood Glucose Monitoring

Updated 8-25-14

EMERGENCY CARE FOR TEACHER'S DESK 2014-2015 School Year

For: Joe Student

Phone numbers:

Sweetie (Mom): Cell: 810-1234

Physician: Dr. Henry
Phone: 954-2551

Student has an intolerance for sugar. It causes his blood glucose to raise dramatically (over 600). His body responds by over producing insulin creating an equally dramatic drop in blood glucose (around 40).

To prevent this, student must refrain from eating sugar laden foods such as juice, regular soda, candy and any kind of gum.

Joe does have a blood sugar monitor in his back pack that travels with him daily.

Joe should eat snack in the morning, a balanced lunch and be allowed access to his water bottle freely during the day.

Altered blood glucose symptoms include:

- Joe not acting like himself – “out of it”
- flushed skin on his face
- complaints of not feeling well
- appears pale
- sweaty
- hallucinations

TREATMENT OF SUSPECTED LOW BLOOD SUGAR

WHAT TO DO: CHECK BLOOD SUGAR IF POSSIBLE

- <80** Give student a complex carbohydrate snack such as crackers with peanut butter. In 15 minutes, recheck blood sugar and repeat the snack if indicated. If student does not respond to treatment, contact parents.
- >80** do nothing.

If at any time Joe becomes unresponsive, administer oral frosting (located in back pack) and DIAL 911.

High Blood Sugars **>180. If blood sugar is >400, CALL MOTHER.**

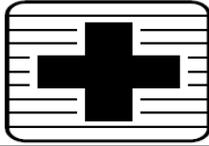
SYMPTOMS OF HIGH BLOOD SUGAR:

- *increased thirst and urination
- cranky
- tired
- same symptoms as low blood glucose

WHAT TO DO:

- Check blood sugar and record.
- Notify parent.
- Allow water and sugar free fluids
- Allow access to bathroom

Latex Plan



Kimberly Area School District

Health Services

Cindy Vandenberg, School Nurse 423-4144
Kathy Verstegen, School Nurse 423-4147
Wendy Van Nuland, School Nurse 423-4150

Student's
Picture

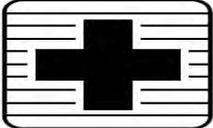
PO Box 159 Combined Locks, WI 54113

Fax (920) 788-7919

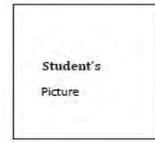
Student's Name:	Joe Student	DOB:	Date: Sept 2014
School Attending:	Great School	Grade: 2	Bus Student: Yes No
Health Condition:	Latex Allergy		
Special Instructions:	Do not use latex gloves or products containing latex on student. Exposure will cause rash and blisters. May not take Benadryl. Treatment of allergic reaction is Claritin or generic equivalent.		
I have reviewed the health plan for my child: The plan is correct as written _____ The plan is correct with the changes noted above _____			
Student health information is shared via email, copies of health plans and/or staff meetings with grade level teachers, coaches, bus company and office staff. Elementary/Intermediate Students ONLY: Yes _____ No _____ I would also like ALL school staff to be aware of my child's health condition via powerpoint presentation at an ALL school staff inservice			
Parent's Signature:			Date:

Rev 05/2014, white

Dietary Order



**Kimberly Area School District
Health Services**
Cindy Vandenberg, School Nurse 423-4144
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Student's Name:	Joe Student	DOB:	Date:	Sept 2014
School Attending:	Great School	Grade:	2	Bus Student: Yes No
Health Condition:	Dietary Restrictions			
Special Instructions:	<p>Student is on a low potassium, low sodium diet due to renal disease. He may not have whole wheat or other foods with high potassium. Mom will work with food services for hot lunch. Only have student eat snacks from home. OK for moderate portion of treats brought in for special occasions such as parties, birthdays, etc.</p> <p>DPI "Children with Disabilities and Special Dietary Restrictions" form on file: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>I have reviewed the health plan for my child: The plan is correct as written <input type="checkbox"/> The plan is correct with the changes noted above <input type="checkbox"/></p> <p>Student health information is shared via email, copies of health plans and/or staff meetings with grade level teachers, coaches, bus company and office staff.</p> <p>Elementary/Intermediate Students ONLY: Yes <input type="checkbox"/> No <input type="checkbox"/> I would also like ALL school staff to be aware of my child's health condition via powerpoint presentation at an ALL school staff inservice.</p>				
Parent's Signature:				Date:

Rev 05/2014

Principal Initials _____

Dietary Order

Eating and Feeding Evaluation: Children with Special Needs

FIGURE 1: PART A		
Student's Name	Age	
Name of School	Grade Level	Classroom
Does the child have a disability ? If Yes, describe the major life activities affected by the disability.	Yes	No
Does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a licensed physician .	Yes	No
If the child is not disabled , does the child have special nutritional or feeding needs? If Yes, complete Part B of this form and have it signed by a recognized medical authority .	Yes	No
If the child does not require special meals, the parent can sign at the bottom and return the form to the school food service.		
PART B		
List any dietary restrictions or special diet.		
List any allergies or food intolerances to avoid.		
List foods to be substituted.		
List foods that need the following change in texture. If all foods need to be prepared in this manner, indicate "All." Cut up or chopped into bite size pieces: Finely ground: Pureed:		
List any special equipment or utensils that are needed.		
Indicate any other comments about the child's eating or feeding patterns.		
Parent's Signature	Date:	
Parent's Printed Name and Phone Number		
Physician or Medical Authority's Signature	Date:	
Physician or Medical Authority's Printed Name and Phone Number		

Are We Done Yet?

Implement (Step 4)

- ▶ Now let's *Implement*... Meet with parent, student and staff that will be working with student during the school year once plan is completed.
- ▶ Review of plan and make needed changes.
- ▶ Obtain required signatures (parent, physician and principal).
- ▶ Provide training with competencies to staff who will provide cares.

And Into the Future...

- ▶ Step 5 of the nursing process is *Evaluation*.
- ▶ Your documents are part of an ongoing process.
- ▶ Plan to at least annually review the IHP and other documents with parents, student and staff. A meeting with involved parties works great! Find out what is working well, what needs improvement and what has changed. You may have to do this more often if indicated by student, staff, parents, physician, etc.
- ▶ Staff trainings should take place at least annually or more often depending on complexity of task, change in staff, change in procedure, etc.
- ▶ Monitoring of staff should take place on a “regular” basis. In my district, the nurses are in the schools weekly and assist with delegated cares on those days as a way of monitoring UAP.

Questions

