inclusion matters!

SECTION 9

Plan for Health and Safety Needs

Plan for Health and Safety Needs

All students deserve a secure educational environment which provides supports for any medical, health and safety needs. Traditionally, schools have dealt with students needing assistance with medication, allergies and seizures. Students may also require daily assistance with medical technology including students dependent on tube feeding, respiratory care, intravenous feeding/medication, catheterization, ostomy care and dialysis. A detailed health care plan anticipates and prevents potential problems concerning a student's health and safety needs.

Teamwork is the most essential aspect of including students with special health care needs in the general education setting. The IEP team in place to address educational issues can also address the special health care needs of the student with the school nurse providing the leadership in coordinating the student's health care plan.

The planning team's function is to identify health and safety concerns, determine who is responsible for implementing each aspect of the student's health care and identify the training needed for responsible personnel. This information can be organized into a health care plan that would vary depending on the needs of the student.

The school nurse, or designated health care coordinator, is responsible for:

- Generating a nursing assessment of the child, based on a home, hospital or school visit.
- Obtaining pertinent medical and psychological information.
- Developing a health care plan for the student in collaboration with the family, student and physician.
- Ensuring that a child-specific emergency plan is in place. This should be developed in collaboration with school administration, community emergency personnel and family, and would include plans for fire, earthquake and tornado emergencies.
- Attending the education planning meetings, reviewing the health care plan, making recommendations for placement, staffing and training, when pertinent, based on the student's health care needs.
- Coordinating the student's in-school health care as specified in the health care plan.
- Ensuring that care-givers in the school have received competency-based training in appropriate child-specific techniques and problem management.
- Providing information for other personnel and students in the education setting about the special medical needs of the student, when appropriate.
- Maintaining appropriate documentation.
- Regularly reviewing and updating the health care plan and training of care-givers, based on the student's medical condition.

Suggested forms for use in emergency planning can be found on SSD Life (staff only). In addition, nurses can access forms addressing specific medical conditions (asthma, seizures, insect sting, and specialized nursing intervention) on the nursing site on SSD Life.

For additional information on Emergency Care Plans, please visit the Inclusive Education page on the SSD website.

SPECIAL SCHOOL DISTRICT OF ST. LOUIS COUNTY
12110 CLAYTON ROAD
TOWN & COUNTRY, MO 63131
(314) 989-8100

STUDENT INFORMATION EXCHANGE FORM

SSD#	Student	Birthdate

Parent/Guardian or Eligible Student:	
Address:	
City/State/Zip	
Home Telephone:	**Business Phone:**

I hereby give my permission for the Special School District of St. Louis County to:

☐ **OBTAIN the following information from:** ☐ **RELEASE the following information to:**

☐ **Written Exchange** ☐ **Verbal Exchange** ☐ **Both**

Name:	
Attention:	
Address:	**Telephone:**
City/State/Zip:	**Fax:**

☐ **Individual Education Program (IEP)**
☐ **Evaluation Summary**
☐ **Other (*Please Specify*)** _____
☐ **Other (*Please Specify*)** _____

FOR REQUEST TO OBTAIN INFORMATION, please send the above requested information to:

Special School District of St. Louis County	
Department/Region:	**Attention:**
Address: 12110 Clayton Road	**Dept./Region Telephone:**
City/State/Zip: Town & Country, Missouri 63131	**Dept./Region Fax:**

I understand this authorization is specifically for the records above and is for educational purposes. I further understand that Special School District (SSD) will not release information to any unauthorized person/agency without my written consent. Likewise, I understand that I can obtain an explanation and interpretation of any SSD records by scheduling an appointment with the Student Records Department by calling (314) 989-8170. Unless otherwise revoked, this authorization will expire in one(1) year. Copies of this form and signature(s) are to be considered as valid as the original.

_____ _____

Parent/Guardian Signature or Eligible Student **Date**

Distribution of copies: ***Original*** **to Releasing Agency** ***Yellow*** **to SSD Pupil Personnel**
Pink **to SSD Teacher file** ***Goldenrod*** **to Parent/Guardian or Eligible Student**

05/2003

SPECIAL SCHOOL DISTRICT - EMERGENCY CARE PLAN

Emergency Care Plan effective _____ to _____ Review date _____

Student name_____ School year _____

Parent phone _____ Parent cell _____

Alternate contact (name & relationshp) _____ Phone _____

Primary physician (name) _____ Phone _____

STUDENT SPECIFIC DATA FOR CLASSROOM

If you see this:	Do this:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

STUDENT SPECIFIC DATA FOR COMMUNITY

If you see this:	Do this:
_____	_____
_____	_____
_____	_____
_____	_____

Additional comments:

_____

_____

_____ _____

School Nurse Phone

Rev. 1/28/05

In Case of Emergency

- **Stay with the Student**
- **Call or designate someone to call the nurse**
    - State who you are
    - State where you are
    - State problem
- **School nurse will assess the child and decide whether the emergency plan will be implemented**
- **If the nurse is unavailable, the following staff members are trained to initiate the emergency plan:**

SSD QUESTIONNAIRE FOR PARENT OF A STUDENT WITH SEIZURES

(Adapted from the Epilepsy Foundation 5/20/09) Form SZ #3
Please complete all questions. This information is essential for the school nurse and school staff in determining your student's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

CONTACT INFORMATION:

Student's Name:_____ School Year:_____ Date of Birth:_____
School:_____ Grade:_____ Classroom:_____
Parent/Guardian Name:_____ Tel. (H):_____ (W):_____ (C):_____
Other Emergency Contact:_____ Tel. (H):_____ (W):_____ (C):_____
Child's Neurologist:_____ Tel:_____ Location:_____
Child's Primary Care Dr.:_____ Tel:_____ Location:_____
Significant medical history or conditions:

SEIZURE INFORMATION:

1. When was your child diagnosed with seizures or epilepsy?_____
2. Seizure type(s):

Seizure Type	*Length*	*Frequency*	*Description*

3. What might trigger a seizure in your child?_____
4. Are there any warnings and/or behavior changes before the seizure occurs? YES NO
   If YES, please explain:_____
5. When was your child's last seizure?_____
6. Has there been any recent change in your child's seizure patterns? YES NO
   If YES, please explain:_____
7. How does your child react after a seizure is over?_____
8. How do other illnesses affect your child's seizure control?_____

BASIC FIRST AID: Care and Comfort Measures

9. What basic first aid procedures should be taken when your child has a seizure in school?_____

Basic Seizure First Aid:
- ✓ Stay calm & 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 (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

10. Will your child need to leave the classroom after a seizure? YES NO
    If YES, What process would you recommend for returning your child to classroom:_____

SEIZURE EMERGENCIES

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)_____

_____

_____

_____

_____

12. Has child ever been hospitalized for continuous seizures? YES NO

If YES, please explain: _____

_____

A Seizure is generally considered an Emergency when:

- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or diabetic
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water

SEIZURE MEDICATION AND TREATMENT INFORMATION

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and time of day taken	Possible side effects

14. What emergency/rescue medications needed medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to do after administration:

* *After 2nd or 3rd seizure, for cluster of seizure, etc.* ** *Orally, under tongue, rectally, etc.*

15. What medication(s) will your child need to take during school hours?_____
16. Should any of these medications be administered in a special way? YES NO

If YES, please explain:_____

17. Should any particular reaction be watched for? YES NO

If YES, please explain:_____

18. What Does your child have a Vagus Nerve Stimulator? YES NO

If YES, please describe instructions for appropriate magnet use:_____

_____

SPECIAL CONSIDERATIONS & PRECAUTIONS

22. Check all that apply and describe any considerations or precautions that should be taken

- ❑ General health_____
- ❑ Physical functioning_____
- ❑ Learning:_____
- ❑ Behavior:_____
- ❑ Mood/coping:_____
- ❑ Physical education (gym)/sports:_____
- ❑ Recess:_____
- ❑ Field trips:_____
- ❑ Bus transportation:_____

Other:_____

GENERAL COMMUNICATION ISSUES

23. What is the best way for us to communicate with you about your child's seizure(s)?_____

_____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? YES NO

Parent/Guardian Signature:_____ Date:_____ Dates Updated:_____, _____

TRANSPORTATION PLAN

NAME:_____ SCHOOL: _____
PARENTS:_____ NURSE:_____
DOB:_____ NURSE CONTACT #:_____
Delegation Training is required: ____ yes ____ no

___ Student has a possibility for **BREATHING CONCERNS:** Keep student upright and **call 911** if:

- Student is breathing hard and fast
- Student's coloring is bluish or very pale
- Student passes out

USEFUL INFORMATION:
- Keep bus windows closed during allergy season
- Turn off engine when idling for more than 2 minutes
- Make sure air conditioning and heaters are in working order

___ Student is **ALLERGIC** to_____

- Give Epi-Pen and call 911 if any of the following are noted:_____

_____

NO staff or students should have open food on bus.

EPI-PEN PRECAUTIONS
- Must be passed between adults ONLY.
- Keep out of reach of students.
- DO NOT expose to direct sunlight or AC/heat vents.

ADMINISTRATION OF EPI-PEN
- Remove cap (will be gray or blue)
- Hold tip near outer thigh
- Swing & jab firmly into outer thigh thru clothing
- Hold in place & count to 10
- Remove unit & massage area for 10 seconds
- Place student on side

___ Student has a **SEIZURE DISORDER.**

Student's seizures typically look like:_____

Call 911 if _____

FIRST AID FOR GENERALIZED SEIZURES
- Stay calm and track time
- Keep student safe
- Do not restrain
- Do not put anything in mouth
- Stay with student until fully conscious
- Record seizure
- ***For tonic-clonic seizure***: Protect head; Keep airway open/watch breathing; Turn student on side

___ Student has **Other Precautions:** _____

_____

_____

_____

SPECIAL SCHOOL DISTRICT OF ST. LOUIS COUNTY
EMERGENCY CONTACT FORM School Year_____

STUDENT DATA:

Name:_____ Student ID_____
Last First MI

Date of Birth:_____ Gender: Male / Female Race: _____

Student Address: _____
Street Number City, State Zip Code

Home District:_____ Attending School:_____

***MOTHER'S** INFORMATION*

Name:_____

Spouse:_____

Address: _____

_____

Home Phone:_____Cell:_____

Email:_____

Employer's Name:_____

Work :_____ (*Contact Priority___)

FATHER'S INFORMATION

Name:_____

Spouse:_____

Address: _____

_____

Home Phone:_____Cell:_____

Email:_____

Employer's Name:_____

Work Telephone:_____ (*Contact Priority___)

*Contact Priority: Please indicate the order we are to use when calling in the case of emergency or illness.

FOR EMERGENCY USE WHEN PARENT CANNOT BE LOCATED: Persons listed below has your authorization to pick up your child.

Name:_____

Relationship:_____

Home Phone:_____Cell:_____

Work:_____ (*Contact priority____)

Name:_____

Relationship:_____

Home Phone:_____Cell:_____

Work:_____ (*Contact priority____)

HEALTH CARE PROVIDERS

Family Physician: _____ Telephone:_____

Hospital:_____

Insurance Plan:_____Membership Number:_____

Dentist:_____Telephone:_____

EMERGENCY PROCEDURE: In case of injury or illness requiring medical care, you have my permission to obtain such care from the nearest hospital and to release personally identifiable information regarding my child. I agree to pay all expenses incurred in such emergency care.

Signature:_____ Date:_____

Health Information: To be completed by parent or guardian prior to entry into Special School District

Does pupil have a history of? ☐ Asthma ☐ Diabetes ☐ Heart Condition ☐ Convulsive Disorder

☐ Allergies List:_____

Other Medical Concerns:_____

_____

Medications: List all medications, give name(s), amounts and time medication is taken:_____

_____

_____

Hearing Loss? ◯/◯ Hearing Aid(s)? ◯/◯ Contact Lenses? ◯/◯ Eye Glasses? ◯/◯

Date of last physical exam:_____ Date of Tetanus Booster: _____

SPECIAL SCHOOL DISTRICT
HEALTH SERVICES

PARENT/GUARDIAN REQUEST FOR ADMINISTRATION OF MEDICATIONS AT SCHOOL

I request and give my permission for Special District Registered Nurses, or their designee, to administer the following medication(s) (listed below) to my child_____ and to consult with my child's physician(s) _____ at (phone)_____regarding any concern or questions in reference to the administration of medication during the _____/_____ school year.

Please list each medication you are requesting your child be given at school

	Drug Name	Dose	Time
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

All medications to be administered at school must be given to the school nurse in a current pharmacy container labeled with the following information:

- Child's name
- Authorized provider's name
- Pharmacist's name and phone
- Prescription number
- Date prescription filled
- Specific instructions for administering
- Name of medication

We will not administer any medication unless labeled as above. This may require that your child's authorized provider write two prescriptions(one for home use and one for school use) so the pharmacist can separate the medication into two labeled containers. Some pharmacies will provide you with a "school bottle".
Exception: Over the counter medication must be brought in an unopened bottle and be accompanied by a written prescription from the physician.

It is the parent's/guardian's responsibility to notify the school nurse when medication is changed and/or discontinued.

_____ _____

Parent/Guardian signature Date

Rev. 4/14/09

INSTRUCTIONS FOR PHYSICIANS

This child attends a Special School District school. It is important that we are aware of any medical or mental conditions and/or changes. This information will be vital in planning an educational and/or health care plan. Your input is appreciated. Thank you.

HISTORY OF ILLNESS

DATE		
	Accidents (types)	
	Allergies (types)	
	Congenital Defects	
	Chicken Pox	
Seizures (type)		

RECORD OF IMMUNIZATIONS

	Date	Date	Date	Boosters
DPT/DTaP*				
DT*				
Td*				
OPV*				
IPV*				
MMR*				
HIB - ECE*				
HEP A				
HEP B*				
VARIVAX*				
Other				

* These are required by state law for school attendance.

	Date	Results	Date	Results
PPD				

Lead Screening: Positive ☐ Negative ☐

PHYSICAL EXAMINATION

Date_____ Height_____ Weight _____

Vision acuity_____ Conjunctivae _____

OD _____ OS _____ OU _____ Pupils _____

Hearing acuity_____ TMs _____

Nose _____Throat _____

Mouth/teeth _____ Lymph nodes _____

Thyroid _____ Spine _____

Heart _____ Rate/Rhythm _____

Lungs _____ BP _____

Abdomen _____ Hernia _____

Genitalia _____ Extremities _____

Skin _____ CNS _____

Diagnosis _____

_____

_____

Current Medications and dosages _____

_____

_____

Physician Recommendations for Eating/ Feeding/Nutrition at School

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 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 peices: 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:	
Physician or Medical Authority's Signature		Date:	

Protocol for Specialized Nursing Intervention or Treatment

Students who need specialized health care procedures during the school day must have, in writing, a physician's order and parent/guardian permission. When necessary, the Specialized Nursing Interventions or Treatment form will be given to the parent/physician for completion.

If applicable, a copy of the nursing intervention planned for the student may be attached to the Physician Order form for review and modification by the physician.

When the parent/guardian and/or physician return the completed forms, they will be filed in the student's health record.