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.
-确保特定的紧急计划生效。这应与学校行政人员、社区紧急人员以及家庭合作开发，其中包括计划应对火灾、地震和龙卷风等紧急情况。
- 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.
# STUDENT INFORMATION EXCHANGE FORM

<table>
<thead>
<tr>
<th>SSD#</th>
<th>Student</th>
<th>Birthdate</th>
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<tbody>
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</table>

**Parent/Guardian or Eligible Student:**

**Address:**

**City/State/Zip**

**Home** | **Business**

**Telephone:** | **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:

**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 | **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
- Pink to SSD Teacher file
- Yellow to SSD Pupil Personnel
- Goldenrod to Parent/Guardian or Eligible Student

**05/2003**
Emergency Care Plan effective ____________ to _____________ Review date ______

Student name__________________________ School year _________________________
Parent phone __________________________ Parent cell __________________________
Alternate contact (name & relationship) ____________________________ Phone ____________
Primary physician (name) ____________________________ Phone ____________

### STUDENT SPECIFIC DATA FOR CLASSROOM

<table>
<thead>
<tr>
<th>If you see this:</th>
<th>Do this:</th>
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### STUDENT SPECIFIC DATA FOR COMMUNITY

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<th>If you see this:</th>
<th>Do this:</th>
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Additional comments:
_________________________________________________________________________________
_________________________________________________________________________________
________________________________________________________________________

_________________________________________ Phone ____________
School Nurse 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):

<table>
<thead>
<tr>
<th>Seizure Type</th>
<th>Length</th>
<th>Frequency</th>
<th>Description</th>
</tr>
</thead>
</table>

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? _______________________________________________________
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

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:

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

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: __________________________________________________________

SEIZURE MEDICATION AND TREATMENT INFORMATION

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Date Started</th>
<th>Dosage</th>
<th>Frequency and time of day taken</th>
<th>Possible side effects</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Administration Instructions (timing* &amp; method**)</th>
<th>What to do after administration:</th>
</tr>
</thead>
<tbody>
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</table>

* 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________________________☐ Physical education (gym)/sports:________
☐ Learning:________________________________☐ Recess:_______________________________
☐ Behavior:________________________________☐ Field trips:__________________________
☐ Mood/coping:________________________☐ 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: ___________________________

<table>
<thead>
<tr>
<th>NO staff or students should have open food on bus.</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPI-PEN PRECAUTIONS</td>
</tr>
<tr>
<td>• Must be passed between adults ONLY.</td>
</tr>
<tr>
<td>• Keep out of reach of students.</td>
</tr>
<tr>
<td>• DO NOT expose to direct sunlight or AC/heat vents.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADMINISTRATION OF EPI-PEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Remove cep (will be gray or blue)</td>
</tr>
<tr>
<td>• Hold tip near outer thigh</td>
</tr>
<tr>
<td>• Swing &amp; jab firmly into outer thigh thru clothing</td>
</tr>
<tr>
<td>• Hold in place &amp; count to 10</td>
</tr>
<tr>
<td>• Remove unit &amp; massage area for 10 seconds</td>
</tr>
<tr>
<td>• Place student on side</td>
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</tbody>
</table>

___ Student has a SEIZURE DISORDER.

Student’s seizures typically look like: ___________________________

Call 911 if: ___________________________

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

___ Student has Other Precautions: ___________________________

__________________________

__________________________

__________________________

__________________________
SPECIAL SCHOOL DISTRICT OF ST. LOUIS COUNTY
EMERGENCY CONTACT FORM

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___)

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: _____________
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

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dose</th>
<th>Time</th>
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<tbody>
<tr>
<td>1.</td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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</table>

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
- Date prescription filled
- Specific instructions for administering
- Name of medication
- Prescription number

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

<table>
<thead>
<tr>
<th>DATE</th>
<th>Accidents (types)</th>
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<tbody>
<tr>
<td></td>
<td>Allergies (types)</td>
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<tr>
<td></td>
<td>Congenital Defects</td>
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<td></td>
<td>Chicken Pox</td>
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<tr>
<td></td>
<td>Seizures (type)</td>
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</tbody>
</table>

RECORD OF IMMUNIZATIONS

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<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Boosters</th>
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<td>DPT/DTaP*</td>
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<td>DT*</td>
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<td>OPV*</td>
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<td>Hib - ECE*</td>
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<tr>
<td>Hep A</td>
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<td>Hep B*</td>
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<tr>
<td>VARIVAX*</td>
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<tr>
<td>Other</td>
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</table>

* These are required by state law for school attendance.

<table>
<thead>
<tr>
<th>Date</th>
<th>Results</th>
<th>Date</th>
<th>Results</th>
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<tbody>
<tr>
<td>PPD</td>
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</table>

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

<table>
<thead>
<tr>
<th>Student's Name</th>
<th>Age</th>
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<tr>
<th>Name of School</th>
<th>Grade Level</th>
<th>Classroom</th>
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Does the child have a disability? If Yes, describe the major life activities affected by the disability.

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.

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:

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.