# Carroll ISD Health Services
# Parental Authorization- Spina Bifida Action Plan 2020-2021

| **Parent please answer:** | |
|---|---|
| Special Ed services? | yes / no |
| Active 504 plan? | yes / no |
| I would like 504 information | yes / no |

Name:_____ D.O.B.:_____ Grade/Teacher:_____
Parent/Guardian: _____ Phone: _____
Parent/Guardian: _____ Phone: _____
Transportation: ☐ Car rider ☐ Walker ☐ Drives self ☐ Rides bus # _____
Before/After school activities: ☐ Athletics ☐ Band ☐ Club: _____ ☐ Tutoring ☐ Other_____
**Diagnosis/Significant medical history**:_____
_____
Allergies:_____
Current **Medications**: _____
_____
Keep in Clinic? ◯ yes ◯ no If so, please provide a completed **M**edication **A**dministration **R**ecord.
**Procedures/ Devices:**_____
_____
**Specific Activity limitations or Restrictions**: Yes/ No (explain):
PE/ Outdoor Activity/ recess:_____
Athletics/ Extra-Curricular: _____
Other:_____
Elimination Needs ◯ yes ◯ needs assistance ◯ no
Meals ◯ yes ◯ needs assistance ◯ no
Transportation Needs ◯ yes ◯ needs assistance ◯ no

**Standard Spina Bifida Action Plan for School**- Please review and make changes/ additions as needed.

| **Problem** | **Actions** |
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| Mobility<br><br>**Attach Doctor's Order for Physical Restrictions* | ☐ambulatory/ no equipment ☐wheelchair ☐crutches ☐gait trainer ☐orthotics<br>☐Other: _____<br>**Specific Activity Limitations or Restrictions**: Yes/ No (explain):<br>Outdoor Activity/ recess:_____<br>Athletics/ Extra-Curricular: _____<br>Please specify Mobility issues:_____<br><br>o Monitor environment for fall/trip hazards<br>o No contact sports<br>o Use ramps; no stairs<br>o Avoid crowded halls, may need to leave classroom early<br>o Aide assistance changing classes<br>o Reduce clutter in rooms |
| Urinary Elimination | ☐ No assistance needed<br>☐Catheterization ☐Self ☐Staff Assist**-requires Dr. Order*<br>☐Vesicostomy ☐Self ☐Staff Assist<br>☐Urostomy ☐Self ☐Staff Assist<br>☐Diapering Procedure<br>Able to transfer to toilet alone ◯never ◯rarely/sometimes ◯often ◯consistently<br>Free of Urine Leakage ◯never ◯rarely/sometimes ◯often ◯consistently<br>Sets up supplies for catheterization ◯never ◯rarely/sometimes ◯often ◯consistently<br>Performs self-catheterization alone ◯never ◯rarely/sometimes ◯often ◯consistently<br>Absence of urinary tract infections ◯never ◯rarely/sometimes ◯often ◯consistently<br>See page 3 for Bladder Schedule<br>o Establish bathroom schedule/routine- every ___ hours |

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| | ○ Private, easily accessible location for procedure<br>○ Watch for signs/symptoms of urinary infection<br>○ Encourage independence with toileting but aide or nurse to provide assistance as needed<br>○ Notify parent/legal guardian if any need<br>○ Parent/legal guardian to provide all supplies/equipment for procedure<br>○ Complete toileting record |
| Stool Incontinence | ☐Colostomy ☐Self ☐Staff Assist<br>☐Ileostomy ☐Self ☐Staff Assist<br>Free of bowel incontinence ◯never ◯rarely/sometimes ◯often ◯consistently<br>Performs bowel management program at school ◯never ◯rarely/sometimes ◯often ◯consistently ◯n/a<br>See Page 3 for Bowel Schedule<br>○ Establish bathroom schedule/routine<br>○ Private, easily accessible location for student bathroom use<br>○ Instruct student on toileting hygiene self-care.<br>○ Encourage independence with toileting but aide or nurse to provide assistance as needed.<br>○ Watch for any problems: notify parent/guardian if any need<br>○ Parent/legal guardian to provide all supplies/equipment needed<br>○ Complete toileting record |
| Meal Assistance or Special Diet<br>**Attach Doctor's Order* | ○ What level of assistance needed with meals? _____<br>_____<br>○ Student to be allowed to drink water in class; approx.. _____ oz per day |
| Latex Allergies | ○ Does student have a known latex allergy? ◯yes ◯no<br>○ Notify School Nurse if exposed to latex and showing any sign of allergic reaction- includes but not limited to watery and itchy eyes, sneezing, and coughing, rash or hives, swelling of the windpipe, wheezing, difficulty breathing and/or anaphylactic shock.<br>○ See Severe Allergy Care Plan (please attach) |
| Skin and Infection Protection | Does student have any skin breakdown concerns? ◯yes ◯no<br>If so, where are the areas that cause concern? _____<br>Does student know:<br>Signs/ symptoms of infection ◯yes ◯no<br>Signs/ symptoms of UTI ◯yes ◯no<br>When to notify nurse/ parent of possible infection concern ◯yes ◯no<br>Good hand hygiene ◯yes ◯no<br>Tips for staff to reinforce proper body position/ alignment and monitoring for sources of pressure or friction: _____<br>_____ |
| Transportation and Evacuations | ○ Does student have specific transportation or evacuation needs? ◯yes ◯no<br>○ If so, please describe:<br>_____ |
| Absences | ○ Parent/legal guardian to provide doctor's notes for absences due to medical appointments or illness<br>○ Teacher: notify guidance/nurse if absences become frequent |

| | |
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| Shunt | Does student have a shunt? ◯yes ◯no<br>If so, type and where? _____<br>_____<br>o If signs of increased intracranial pressure (lethargy, irritation, vomiting, vertigo, seizures) occur, contact nurse and parent.<br>o Additional measures in case of suspected shunt malfunction: _____<br>_____<br>See Seizure Care Plan attached. |

| Bladder/Catheterization Schedule | Bowel Schedule |
|---|---|
| | |

**<u>I grant permission to Carroll ISD to follow the above plan for my child. I am giving permission to CISD to contact my physician for additional information as necessary. If the school nurse deems necessary, I grant permission to notify my student's teacher of his/ her health plan.</u>**

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|---|---|
| Physician- Print Name: | Physician Phone: |
| Parent/ Guardian Signature: | Parent/ Guardian Phone: |

Revised 5/11/2020