



**inclusion  
matters!**

SECTION 8

# 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*  
    *Pink to SSD Teacher file*

*Yellow to SSD Pupil Personnel*  
*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 & relationship) \_\_\_\_\_ 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):

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>

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.) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

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?

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 2<sup>nd</sup> or 3<sup>rd</sup> 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: \_\_\_\_\_
- Other: \_\_\_\_\_
- Physical education (gym)/sports: \_\_\_\_\_
- Recess: \_\_\_\_\_
- Field trips: \_\_\_\_\_
- Bus transportation: \_\_\_\_\_

**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

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\_\_\_ 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:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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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                | Date prescription filled                |
| Authorized provider's name  | Specific instructions for administering |
| Pharmacist's name and phone | 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**

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

**RECORD OF IMMUNIZATIONS**

	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.

PPD	Date	Results	Date	Results

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.