**CEREBRAL PALSY HEALTH CARE PLAN**

**NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SCHOOL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GRADE/TEACHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT/GUARDIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEALTH CARE PROVIDER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nurse should initialize and individualize care plan to include only the problems and actions that are applicable for this student.**

|  |  |  |
| --- | --- | --- |
| **DATE/ INITIALS** | **PROBLEM**  |  **ACTIONS** |
|  | **Limited mobility due to stiffness/limpness** | * **Allow rest as needed**
 |
|  | **Use of walking aids, crutches, braces, and splints** | * **Utilize fall prevention strategies**
* **Assist student in carrying books as needed**
* **Allow additional time to change classes as needed**
* **Notify nurse and parent/guardian of any skin breakdown due to walking aids**
 |
|  | **Restricted Activity** | * **Allow rest and restricted activity as order by physician(doctor statement required)**
 |
|  | **Impaired chewing or swallowing** | * **Diet order for meal modification if needed**
* **Adult supervision during eating**
* **Utilize special utensils if required**
* **Know how to locate first responder**
 |
|  | **Socialization** | * **Encourage class participation in daily activities**
* **Promote positive interactions with other students**
 |
|  | **Altered speech pattern** | * **Refer for speech evaluations or services if appropriate**
 |
|  | **Potential for seizure** | * **Initiate Emergency Action Plans for Seizure**
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In order to make sure my child’s special health needs are met, I understand and agree that the information will be shared with school staff/other personnel on a need to know basis in order to provide appropriate care. I understand and agree that the school nurse may contact my child’s doctor about this condition.

**Parent /Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nurse Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**