Carroll ISD Health Services
Parental Authorization- Spina Bifida Action Plan

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

	○ Private, easily accessible location for procedure ○ Watch for signs/symptoms of urinary infection ○ Encourage independence with toileting but aide or nurse to provide assistance as needed ○ Notify parent/legal guardian if any need ○ Parent/legal guardian to provide all supplies/equipment for procedure ○ Complete toileting record
Stool Incontinence	☐Colostomy ☐Self ☐Staff Assist ☐Ileostomy ☐Self ☐Staff Assist Free of bowel incontinence ◯never ◯rarely/sometimes ◯often ◯consistently Performs bowel management program at school ◯never ◯rarely/sometimes ◯often ◯consistently ◯n/a See Page 3 for Bowel Schedule ○ Establish bathroom schedule/routine ○ Private, easily accessible location for student bathroom use ○ Instruct student on toileting hygiene self-care. ○ Encourage independence with toileting but aide or nurse to provide assistance as needed. ○ Watch for any problems: notify parent/guardian if any need ○ Parent/legal guardian to provide all supplies/equipment needed ○ Complete toileting record
Meal Assistance or Special Diet **Attach Doctor's Order*	○ What level of assistance needed with meals? ___________________________________ ____ ○ Student to be allowed to drink water in class; approx.. _____ oz per day
Latex Allergies	○ Does student have a known latex allergy? ◯yes ◯no ○ 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. ○ See Severe Allergy Care Plan (please attach)
Skin and Infection Protection	Does student have any skin breakdown concerns? ◯yes ◯no If so, where are the areas that cause concern? _____________________________________ Does student know: Signs/ symptoms of infection ◯yes ◯no Signs/ symptoms of UTI ◯yes ◯no When to notify nurse/ parent of possible infection concern ◯yes ◯no Good hand hygiene ◯yes ◯no Tips for staff to reinforce proper body position/ alignment and monitoring for sources of pressure or friction: ____ ____
Transportation and Evacuations	○ Does student have specific transportation or evacuation needs? ◯yes ◯no ○ If so, please describe: ____
Absences	○ Parent/legal guardian to provide doctor's notes for absences due to medical appointments or illness ○ Teacher: notify guidance/nurse if absences become frequent

Shunt	Does student have a shunt? ◯yes ◯no If so, type and where? ____ ____ ○ If signs of increased intracranial pressure (lethargy, irritation, vomiting, vertigo, seizures) occur, contact nurse and parent. ○ Additional measures in case of suspected shunt malfunction: _______________ ____ 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>

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

Revised 5/11/2020