



Cleburne ISD Health Services Parental Authorization- Spina Bifida Action Plan

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 **Medication Administration Record**.

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

	<ul style="list-style-type: none"> ○ 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	<input type="checkbox"/> Colostomy <input type="checkbox"/> Self <input type="checkbox"/> Staff Assist <input type="checkbox"/> Ileostomy <input type="checkbox"/> Self <input type="checkbox"/> Staff Assist Free of bowel incontinence <input type="radio"/> never <input type="radio"/> rarely/sometimes <input type="radio"/> often <input type="radio"/> consistently Performs bowel management program at school <input type="radio"/> never <input type="radio"/> rarely/sometimes <input type="radio"/> often <input type="radio"/> consistently <input type="radio"/> n/a See Page 3 for Bowel Schedule <ul style="list-style-type: none"> ○ 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 <i>*Attach Doctor's Order</i>	<ul style="list-style-type: none"> ○ What level of assistance needed with meals? _____ ○ Student to be allowed to drink water in class; approx.. _____ oz per day
Latex Allergies	<ul style="list-style-type: none"> ○ Does student have a known latex allergy? <input type="radio"/>yes <input type="radio"/>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? <input type="radio"/> yes <input type="radio"/> no If so, where are the areas that cause concern? _____ Does student know: Signs/ symptoms of infection <input type="radio"/> yes <input type="radio"/> no Signs/ symptoms of UTI <input type="radio"/> yes <input type="radio"/> no When to notify nurse/ parent of possible infection concern <input type="radio"/> yes <input type="radio"/> no Good hand hygiene <input type="radio"/> yes <input type="radio"/> no Tips for staff to reinforce proper body position/ alignment and monitoring for sources of pressure or friction: _____ _____
Transportation and Evacuations	<ul style="list-style-type: none"> ○ Does student have specific transportation or evacuation needs? <input type="radio"/>yes <input type="radio"/>no ○ If so, please describe: _____
Absences	<ul style="list-style-type: none"> ○ 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	<p>Does student have a shunt? <input type="radio"/>yes <input type="radio"/>no</p> <p>If so, type and where? _____</p> <p>_____</p> <ul style="list-style-type: none"> ○ If signs of increased intracranial pressure (lethargy, irritation, vomiting, vertigo, seizures) occur, contact nurse and parent. ○ Additional measures in case of suspected shunt malfunction: _____ <p>_____</p> <p>See Seizure Care Plan attached.</p>
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Bladder/Catheterization Schedule	Bowel Schedule

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.

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