Nixa Schools Health Services

Incontinence Action Plan

Student Name_____DOB_____Grade_____School Year_____

History

☐ Constipation ☐ Catheter* ☐ Colostomy* ☐ Urinary Incontinence
☐ Bowel Incontinence ☐ Irritable Bowel Syndrome ☐ Other_____

Explain any additional needs to help control issues in the school environment:

- Dietary changes*_____
- Hydration requirements _____
- Medications*_____
- Bathroom access _____
- Skin treatment*_____

**Additional forms may be required*

While at school, my child's incontinence issues will require:

☐ NO ASSISTANCE with hygiene and/or clothing changes.
☐ SOME ASSISTANCE with hygiene and/or clothing changes.
☐ FULL ASSISTANCE with hygiene and/or clothing changes.
☐ PARENT TO BE CALLED TO ASSIST with hygiene and/or clothing changes.

Additional Parent Comments:

_____

_____

Supplies to be provided by parents:

☐ Change of clothes ☐ Colostomy supplies ☐ Pull-up or diapers
☐ Wipes ☐ Catheter supplies ☐ Other_____

Parent Consent

I, the parent/guardian of the above names student, request that this Incontinence Plan be used to guide the care of my child. I agree to or permit:

- Provide necessary supplies.
- My child receiving assistance by their current building nurse, their teacher and/or para as needed unless otherwise specified (per instructions above).
- Notify the school nurse of any changes in my student's health status.
- Notify the school nurse and complete new consent for changes in orders from the student's health care provider.
- School staff interacting directly with my child be informed about their assistance needs while at school
- The school nurse to communicate with my student's physician/specialist about their incontinence as needed.

Parent Signature_____Date_____

Physician Consent

I have reviewed and approve this Incontinence Action Plan as written with my additional recommendations listed below:

_____

_____

Physician Signature_____Date_____
Physician Name (printed)_____Phone_____