Postural Orthostatic Tachycardia Syndrome (POTS)

Individualized Health Plan

Student ______________________________ **DOB** ____________________ **School year** ________________

POTS is an acronym for **Postural Orthostatic Tachycardia syndrome.** It is characterized by dysfunction of the autonomic nervous system which controls many "automatic" physiological functions including blood pressure, heart rate, blood vessel and pupil diameter, movement of digestive tract, and body temperature. One can suffer from a wide range of symptoms.

Hallmark symptoms – Orthostatic intolerance: Because the autonomic nervous system is not functioning correctly, the constriction of blood vessels that normally occurs when we transition from sitting to standing is decreased or absent. This lack of vessel constriction leads to blood pooling in the legs and abdomen, which results in a shortage of blood in the heart and brain.

Problem	Actions
• Dizziness. • Light-headedness. • Pale facial color * Nausea * Sensation of feeling hot * Chest pain/palpitations	1. **Immediately** have student lie flat. Elevate feet 2. Remain flat until facial color returns. 3. DO NOT raise head – this could cause seizure. 4. Pulse may be fast at first, then slow down as student recovers from episode.
• Fainting	1. Assist student to ground, if possible, lie flat. 2. DO NOT raise head – this could cause a seizure. 3. Call 911, if student not regain consciousness or is not breathing. 4. Begin CPR, if needed.
• Exercise may cause episode	1. Immediately stop exercising or the activity. 2. Follow instructions noted above.
Medication** *List:*______________________	Follow instructions on Medication Administration Authorization Form. *****Attach medication authorization form.***
Prevention measures include: • Adequate hydration and salt intake • Avoid long periods of standing • A Buddy Pass to be on hand for dizziness or light-headedness	1. Allow/encourage intake of water and/or Gatorade throughout the day 2. Allow bathroom privileges as needed 3. Allow salty snacks throughout the day 4. Allow student to sit down or recline, when possible. 5. A friend can help carry books, supplies, etc., if feeling dizzy or light-headed.

List other actions or recommendations to help with this problem:

____

____

____

______________________________ ______________________ ______________

Parent/Guardian Signature Phone# Date

Emergency Contact in the event parent cannot be reached: Name: ______________________________

Phone: ______________________________

FOR SCHOOL USE ONLY

School Nurse Signature: ______________________________ Date: ________________

☐ **Plan reviewed with __________, teachers ________, TA _______, bus driver______ Special area teachers, ___________ First Responders**

Parental Permission and Release of Medical Information:

- As parent/guardian of above student, I consent for the employees of AMSACS to follow the plan and use the designated medications on my child in accordance with the instructions above.
- I understand that I am to provide the school with medication and signed authorization form, supplies, etc. to follow the plan.
- I understand that this plan will be shared to all those who need to know (all student's teachers/office personnel/ bus driver/ emergency responder, etc) unless written objection is stated on this form
- I hereby acknowledge that I have read, understand, and support the Emergency Health Plan.

Release of Medical Information

- I hereby authorize my child's health care provider to release to the school nurse, principal, or other authorized school personnel, specific confidential medical information contained in my child's record regarding his/her medical condition. Only school staff delivering health care services to my child in school will use this information.

______________________________ ____________________

Parent/ Guardian Signature Date

______________________________ ____________________ _______________

Providers Signature Date Phone

______________________________ ____________________

Nurse Signature Date