Northport School District
Hydrocephalus Shunt – Individual Care Plan

Student legal last name _____ First name _____

Birthdate _____ School _____ Grade _____ Other ID # _____

Transportation: ☐ Walker ☐ Self-transported ☐ Bus rider Bus/Route # _____

Parent/Guardian Information

Parent/Guardian _____ Primary Phone _____

Work Phone _____ Cell Phone _____

Parent/Guardian _____ Primary Phone _____

Work Phone _____ Cell Phone _____

Physician & Hospital Information

Physician name _____ Phone _____

Preferred hospital _____ Phone _____

Health concern _____

Location/side of shunt: ☐ Left ☐ Right

Current Medications	
Rescue and Maintenance	
Health History	
Special Precautions/ Instructions	
PE Activity Guidelines	

Emergency Intervention Plan

Mild Symptoms	Immediate Response
Headache, decreased activity, personality changes, decreased school performance, confusion or memory problems, elevation in temperature, lapses in attention, changes in vision.	Contact parent and school nurse. See physician right away.

Additional student information _____

_____

Emergency Intervention Plan (cont.)

Moderate Symptoms	Immediate Response
Vomiting, sleepier than usual, more irritable than usual, headache behind the eyes that does not go away, lethargy.	Contact parent and school nurse. See physician right away. If symptoms are bordering on severe or if there is any doubt, **CALL 911**.

Additional student information _____

_____

Severe Symptoms	Immediate Response
Difficult to wake up, pain or headache down neck, pupils react to light but may be sluggish, constant vomiting.	**CALL 911**.

Additional student information _____

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Critical Symptoms	Immediate Response
Unresponsive, dilated pupils, irregular breath, changes in blood pressure or heart rate.	**CALL 911**.

Classroom accommodations – Modifications

Report concerns to parent/guardian for physician follow-up.

Emergency Contacts

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

☐ I give health services staff permission to communicate with the medical office about this medication.
☐ I understand the medication(s) will not necessarily be given by the school nurse. A designated staff will be trained and supervised.
☐ Medical/medication information may be shared with school staff working with my child and 911 staff if they are called.

Parent/Guardian signature _____ Date _____

School Nurse signature _____ Date _____

Physician signature _____ Date _____

A copy of this plan will be kept in the school office and copies will be given to:

☐ Teacher ☐ PE Teacher ☐ Paraeducator ☐ Transportation ☐ Student Services ☐ Secretary/Principal ☐ Health Room

Other _____