ARLINGTON PUBLIC SCHOOLS
EDUCATE • PREPARE • INSPIRE

To complete this form electronically, it must be opened in *Adobe Reader*!

Reset Form

Hydrocephalus Shunt Individual Care Plan

School year _____

Student legal last name _____ First name _____ MI _____

Birth date _____ School _____ Grade _____ Other ID# _____

Transportation: ☐ Walker ☐ Self Transported ☐ Bus Rider Bus/Route Number _____

Parent/Guardian Information

Parent/Guardian _____ Primary phone _____

Work phone _____ Cell phone _____

Parent/Guardian _____ Primary phone _____

Work phone _____ Cell phone _____

Physician and 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 _____

Adopted 07/08/14
Revised: 06/04/20

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 by may be sluggish, Constant vomiting	**CALL 911**

Additional student information _____

Critical Symptoms	Immediate Response
Unresponsive, Dilated pupils, Irregular breathing, Changes in blood pressure or heart rate	**CALL 911**

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 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:

☐ Para educator ☐ Transportation ☐ Teacher ☐ PE Teacher ☐ Student Services ☐ Health Room ☐ Secretary-Principal

Other _____

CONFIDENTIAL INFORMATION/SHRED PRIOR TO DISCARDING