ARLINGTON
Public Schools

Encopresis Individual Health and 504 Plan

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

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:

Behavior techniques ☐ Yes ☐ No

Please explain

Current medications

Please enter relevant health history

Special precautions/instruction
(i.e. precipitating stressful events, fear or refusal to use the toilet, etc.)

School Intervention Plan

School considerations - Check all that apply

- ☐ Physician directed treatment regimen
- ☐ Toileting schedule ____________ time of day during school day
- ☐ Family provided change of clothing and wipes
- ☐ Private bathroom privileges as needed
- ☐ System for initiating BR visit and clothing change following bowel accidents and/or fecal odor
- ☐ Monitor for signs and symptoms of constipation
- ☐ Encourage fluid intake during the school day
- ☐ Reinforce appropriate personal hygiene regime
- ☐ Progress reporting system with family
- ☐ Counselor involvement as necessary
- ☐ Student's ability for self-care
- ☐ Student's self-esteem

School Intervention Plan

Related Health Concerns - Fever and headache, chronic mega colon from constipation, anorexia, urinary tract infections from chronic obstruction, lesions or perianal dermatitis.

Additional student information ______________________________

Classroom Accommodations - Modifications
Report concerns to parent/guardian for physician follow-up

504 Consent

☐ I DO ACCEPT this accommodation plan. I am aware that there will be an annual review of plan and periodic evaluations (at least every three (3) years). I have received a copy of Section 504 Parent/Student Rights in Identification, Evaluation, and Placement.

☐ I DO NOT ACCEPT this accommodation plan. I am aware that there will be an annual review of plan and periodic evaluations (at least every three (3) years). I have received a copy of Section 504 Parent/Student Rights in Identification, Evaluation, and Placement.

Emergency Contacts

Name ____________ Phone ____________ Relationship ____________

Name ____________ Phone ____________ Relationship ____________

Name ____________ Phone ____________ Relationship ____________

Parent/Guardian Signature *****Original signature required! Please print and sign.***** *(This notation will not print.)* Date ____________

School Nurse Signature *****Original signature required! Please print and sign.***** *(This notation will not print.)* Date ____________

Physician Signature *****Original signature required! Please print and sign.***** *(This notation will not print.)* 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