# SPECTRUM ACADEMY
## Health Care Plan

## CEREBRAL PALSY

**Student Name:** **Date:**

Cerebral Palsy is caused by damage to one or more specific areas of the brain, usually occurring during fetal development or infancy. It also can occur before, during or shortly following birth. "Cerebral" refers to the brain and "Palsy" to a disorder of movement or posture. If someone has cerebral palsy it means that because of an injury to their brain (cerebral) they are not able to use some of the muscles in their body in the normal way (palsy).
Children with cerebral palsy may not be able to walk, talk, eat or play in the same ways as most other children. Depending on which areas of the brain have been damaged, people with cerebral palsy may experience one or more of the following:

- Muscle tightness or spasm
- Involuntary movement
- Disturbance in gait and mobility
- Abnormal sensation and perception
- Impairment of sight, hearing or speech
- Seizures

1. Signs and Symptoms of Health Concern:

2. Would your student verbalize he/she is having difficulty at school related to health concern?

3. Do you think your student holds back from participating in activities at school because of health concern and why?

4. Does student need special considerations related to health concern while at school?
   A. [ ] Modified classroom
   B. [ ] Lunch room considerations (Parent to notify nutrition services)
   C. [ ] Modified PE class
   D. [ ] Modified outside activities
   E. [ ] Field trips
   F. [ ] Seasonal changes
   G. [ ] Emotional or behavioral
   H. [ ] Other:

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5. Does student require medications while at school?
   Medications:

   If your student needs assistance with medication in the school, parent and health care provider must complete Davis School District Authorization of School Personnel to Administer Medication Form. This form must be on file in school office with medication.

6. Additional Information:

## AUTHORIZATION / INFORMED CONSENT / MEDICAL RELEASE

1. I have reviewed and am in agreement with the Health Care Plan and I authorize school officials to provide my child with health care services in accordance with this plan. I understand that my student's health information will need to be shared:
   A. To benefit the student in terms of health maintenance and academic progress.
   B. When necessary to accommodate the safety and well-being of student and staff.
   C. With the discretion of the school nurse to determine what is shared and who should know.

2. I understand that consent for sharing of health information will remain in effect as long as my student is enrolled in Spectrum Academy and may be revoked at any time in writing by parent / guardian.

3. I understand if clarification of the health information is needed, my signature authorized the school nurse to contact the medical provider and authorized the medical provider to release information.

_____ _____

Parent Signature Date

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**Student Name:** **Date:**

_____ _____

School Personnel Signature Date

_____ _____

School Nurse Signature Date

I, _____ agree with and approve the above care plan.

Healthcare Provider - printed name

_____ _____

Healthcare Provider Signature Date