SPECTRUM ACADEMY
Health Care Plan

SHUNT

Student Name: ______________________________ **Date:** ______________________

Shunts are tubes that drain excess cerebral fluid from the brain into the abdominal area. At times the shunt may become clogged or infected causing a malfunction. When it does not drain correctly, it causes the fluid to build up on the brain. Shunts may need to be replaced periodically as a student grows. A fall or blow to the head over the shunt area should be reported to parent/guardian immediately.

1. Student information
   A. Shunt Location: Right or left side? ____________________
   B. Shunt placement date: ____________________
   C. Shunt revision date(s): ____________________
   D. Misc. information:
   ____
   ____

2. Symptoms that may occur when the shunt is not operating properly:
   A. Lethargy, fatigue, drowsiness
   B. Nausea or vomiting
   C. Noise sensitivity
   D. Head, neck or back pain
   E. Swelling along the shunt line
   F. Fever
   G. Eyes rolled downward
   H. Seizure activity
   I. Irritability
   J. Change in level of alertness
   K. Changes in personality
   L. Refusal to eat
   M. Other :

3. Notify parents of any suspected signs or symptoms immediately.

4. Report to parents any blows/injuries to the head area or along the shunt line.
   A.. No contact sports

TITLE

Student Name: ______________________ **Date:** ______________

5. Be aware that dehydration may increase the chance of shunt malfunction.

6. Report any suspicion of dehydration to parent.
   A. Thirst
   B. Dry mouth
   C. Dark colored urine
   D. Flushed skin
   E. Loss of appetite
   F. Fatigue or weakness
   G. Chills

7. Call 911 immediately, even if parents are on their way to school, if student has difficulty breathing or is losing consciousness. If warranted, have trained personnel provide rescue breathing, CPR if indicated.

8. Document all observations and care provided.

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.

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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

______________________________________ ___________________
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