Student: XXXXXX Birth Date: 2/17/2016 **School:Cesar Chavez Preschool** **Grade: Prek DATE OF IHP:**

5/28/2020

CURRENT HEALTH DIAGNOSES and DESCRIPTION:
PERTINENT HEALTH
Otopalatodigital Syndrome Type 1 resulting in skeletal anomalies Gastrostomy tube (G-tube or GT)
Hearing loss

HISTORY: was diagnosed at 4 month of age with Otopalatodigital Syndrome, Type 1. This condition primarily involves abnormalities in skeletal development, mild intellectual disability, conductive hearing loss, and typical facial anomalies. STUDENT has a GT that was placed at 4 months through which he receives the majority of his nutrition. His development appears delayed however he is ambulatory and engaging with adults. He walks independently, wears SMOs and holds his arms high, bent at the elbow for additional balance.STUDENT is now wearing hearing aids. STUDENT's swallowing reflex is intact.

CURRENT MEDICATIONS: AT HOME: Albuterol as needed AT SCHOOL: None at this time

ALLERGIES: No known Drug Allergies

RESTRICTIONS: Activity/Restriction: He may eat foods cut into small bites. Use sign language when possible.

PRECAUTIONS: May have balance issues secondary to low muscle tone

EQUIPMENT AND SUPPLIES: Gastrostomy at School and School-sponsored events as ordered by authorizing healthcare provider.

Health Issue: Alteration in nutrition due to GT dysfunction
PROVIDED BY PARENT: GT replacement kit, feedings for 3 days PROVIDED BY SPECIAL ED DEPT: Gloves
WHERE KEPT AT SCHOOL: TBD
Goal: STUDENT will maintain proper nutrition and hydration during school day.

1. Check to be sure tube is not being pulled. Secure as needed. 2. Check to be sure caps are properly secured.
3. Check for leaking at incision site.
4. Check for signs and symptoms of infection at the GT site. 5. If mini button falls out, unlicensed trained school staff may follow procedure using catheter to maintain temporary ostomy patency. Call parents immediately. Cover with a dry dressing or bandage.

Action: STUDENT will receive GT feeding via bolus as prescribed by authorized healthcare provider. Follow Parent Consent and Authorized Healthcare Provider Authorization for Management of

Outcome: STUDENT will maintain a healthy weight and good hydration.

feeding.
Assess for presence of nausea and vomiting.
Follow Parent Consent and Authorized Healthcare Provider Authorization for Management of Gastrostomy at School and School-sponsored events as ordered by authorizing healthcare provider.
Maintain student in upright or sitting position during feeding and 20-30 minutes after feeding.
Recognize signs and symptoms of aspiration coughing, difficulty breathing, and presence of crackles and wheezing.
Call for assistance in case of aspiration.
Initiate CPR, if needed.

Health Issue: Risk for aspiration related to G-tube feeding

Outcome: Risk of aspiration is decreased as a result of ongoing assessment and early intervention.

Goal: Prevent injury

Health Issue: Increased risk for injury due to impaired physical mobility related to reduced strength and fatigue

Action: xxxx will be monitored for fatigue. xxxxx will be allowed to take frequent rests/breaks as needed. Staff will monitor and support STUDENT so he can independently navigate the classroom and be within close proximity to staff secondary to increased risk of falling.
Outcome: Risk of injury will be decreased.

Goal: Identify early signs of upper respiratory infection

Health Issue: Increased risk of upper respiratory infection secondary to chronic congestion

Action: Monitor xxxxx for signs of coughing, fever, increased secretions, increased fatigue and/or increased fussiness

Goal: xxxxx is free of signs of aspiration and the risk of aspiration is decreased. He will also maintain a patent airway with normal breath sounds.

Outcome: Decreased risk of serious illness

Action: Ensure proper placement of G-tube before

DISASTER PLAN: Evacuation Plan: per classroom and school protocol Three day disaster supplies: GT supplies, GT replacement kit, 3 days worth of formula
Where supplies stored: in classroom, TBD

TRANSPORTATION PLAN:

CALL PARENT/GUARDIAN IF:

FIELD TRIP AND CLASS OUTINGS PLAN: School bus to be arranged

TBD Any unplanned event occurs.

Adapted from *CSNO Greenbook and* Colorado Department of Education

Name: **Procedure:** G-Tube feeding and maintenance **Training Completed:** Name: **Procedure:**
Training Completed:

Parent/Guardian: **Name & Phone #**

Parent/Guardian: Name & Phone #

Healthcare Provider Primary Care Provider & Phone # **Healthcare Provider** Specialist & Phone #
Preferred Hospital:
Preferred Hospital:
Emergency Contact: Name, Relationship & Phone

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school with prescribed medication and equipment devices. I approve this Individualized Healthcare Plan for my child.

_____ _____ _____
Parent/Guardian Parent/Guardian Signature Date

(Linda) Leilani Bell, RN,BSN, PHN _____ _____ School
District Nurse School District Nurse Signature Date

Adapted from *CSNO Greenbook and* Colorado Department of Education