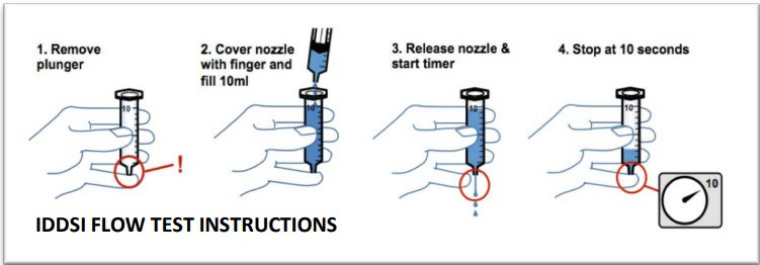


Parent/Guardian:	
Parent/Guardian:	
Primary Care Provider:	
Specialist Provider:	
Preferred Hospital:	
Emergency Contact:	
CURRENT HEALTH ISSUES:	There is a current health condition of Dysphagia. Dysphagia is the medical term for difficulty swallowing. Some people with Dysphagia have a hard time swallowing certain foods or liquids, requiring thickening of liquids to ensure safety and minimize the risk of the liquids going into the lungs.
PERTINENT HEALTH HISTORY:	Liquids need to be mixed to IDDSI level _____ (see attached instructions) Thickener Used: <input type="checkbox"/> SimplyThick <input type="checkbox"/> Gelmix <input type="checkbox"/> Purathick <input type="checkbox"/> _____
ALLERGIES:	
RESTRICTIONS:	<ul style="list-style-type: none"> • Thin liquids (any liquids that are not thickened including drinking from the water fountain) • Hidden thin liquids (grapes, mandarin oranges/clementines, watermelon, tomatoes, ice cream, milkshakes, smoothies, blended ice or juice-based drinks, Slurpees, shaved ice, popsicles, ice cubes/chips, soups/broths, cereal with milk, fruit cups (liquid in container), canned fruits that have liquid in the container)
CURRENT MEDICATIONS:	AT HOME: AT SCHOOL:
HEALTH PROBLEM(S):	
Problem: Increased risk for aspiration	Goal: Minimize risk for aspiration by providing thickened liquids while at school Action: <ul style="list-style-type: none"> <input type="checkbox"/> Ensure all liquids student is drinking are clearly labeled <input type="checkbox"/> When mixing at school, follow the steps below and other provider instructions to ensure liquids are appropriately thickened. <input type="checkbox"/> If appropriate, use feeding supplies provided by family as ordered by provider <input type="checkbox"/> Feed in a sitting position <input type="checkbox"/> Allow adequate time to eat meals or drink liquids <input type="checkbox"/> The thickness of liquids needs to be tested when: <ul style="list-style-type: none"> ○ Any new liquid is being thickened ○ Student is showing signs of aspiration while drinking current thickened liquid ○ First time providing thickened liquids

Revised and adopted by CHCO School Health Program 2020 from CDE http://www.cde.state.co.us/HealthAndWellness/SNH_HealthIssues.htm .

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<p>Problem: Increased risk for aspiration</p>	<p>Goal: Mixing liquids to appropriate thickness as ordered by provider</p> <p>Action: IDDSI flow test:</p> <ol style="list-style-type: none"> 1. Gather supplies (liquid, thickener, two 10ml Luer lock syringes, stopwatch, cup, spoon) 2. Mix ____ packet of _____ (thickener) in ____ oz liquid and mix as instructed (see attached instructions for mixing instructions) 3. Draw up 10mL of thickened liquids with one syringe 4. Remove plunger from the other syringe and cover nozzle with finger 5. Fill second 10mL syringe with 10mL of thickened liquids 6. Release finger from nozzle and start timer 7. When the timer reaches 10 seconds, place your finger over the nozzle and measure how much liquid is left in the syringe and compare it to IDDSI chart (attached) to ensure liquid is thickened appropriately.  <p style="text-align: center;">IDDSI FLOW TEST INSTRUCTIONS</p>
<p>Problem: Increased risk for aspiration or choking</p>	<p>Goal: Monitor for signs of aspiration and/or choking</p> <p>Action: If student is showing any of the following signs of aspiration, have the student stop eating/drinking and call family immediately:</p> <ul style="list-style-type: none"> - Coughing - Choking - Hoarseness - Fever - Wet sounding voice - Watery eyes <p>If student is showing the following signs of aspiration, call 911 immediately:</p> <ul style="list-style-type: none"> - Skin turning blue - Difficulty breathing
<p>Problem: Increased risk for aspiration or choking</p>	<p>Goal: Identify appropriate mixing ratios per liquid</p> <p>Action: <i>Example: Water = 1 packet per 4 oz</i></p> <p>_____ (liquid type) = _____ packet(s) per _____ oz</p> <p>_____ (liquid type) = _____ packet(s) per _____ oz</p> <p>_____ (liquid type) = _____ packet(s) per _____ oz</p>

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Problem:	Goal: Action:
EMERGENCY ACTION PLAN	Shelter in place Evacuation plan

Personal Care Services/ Medically Necessary Services *(repeat segment if more than one service)*
ICD-10 Code:

Specific task: *example: feeding, cath, diaper change*

Scope: *What is the related service that is needed for the student?*

Duration: *How long does the service take? (minutes or hours/per instance)*

Frequency: *How many times does it need to be done per day? (number times per day or as needed)*

This service is medically necessary through the following dates, not to exceed one year.

Start Date: **End Date:**

TO THE PARENT/GUARDIAN: If _____ experiences a change in his/her health condition (such as a change in medication or a hospitalization) please contact the School Nurse Consultant so that this Health Care Plan can be revised, if needed. Parent/guardian signature indicates permission to contact the child's health care provider(s) listed above, as needed. I understand that the School Nurse Consultant may delegate this health care plan to unlicensed school personnel. I give permission for school personnel to carry out this care plan for the Child. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure the Child's safety and well-being while at school or during school related activities.

parent/guardian date

school nurse date

health care provider date

administrator date

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