CUMBERLAND COUNTY SCHOOLS
Shunt Action Plan

Student: ____ DOB: _____________ Age: _______________

School: ______________________________ Grade: ____________ Teacher: ______________________________

Bus Information: Bus No.______ Bus Driver A.M. __________________ Bus Driver P.M. _________________________

A shunt is a tube inside the ventricle of the brain, to help drain excess fluid and reduce pressure inside the head.

Call the parent/guardian immediately if the following signs or symptoms occur, which might be an indication of shunt malfunction or blockage:

1. Fever greater that 100.0 °F
2. Vomiting/loss of appetite
3. Headache
4. Irritability, tiredness, abnormal sleepiness, stiff neck
5. Vision problems
6. Loss of coordination or balance
7. Swelling or redness along the shunt tract
8. Difficulty staying awake
9. Seizures
10. Decline in academic performance
11. Personality change
13. Refusal to eat
14. Noise sensitivity
15. Loss of consciousness
16. List others specific to this student:
    ____
    ____
    ____

Additional Instructions: Avoid any blows to the head. Notify parent/guardian of symptoms immediately. _____________

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List Physical Limitations: ____

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Medications at School: (If medications are needed at school a Physician's signature is required.)
All medication for use at school will be furnished by parent/guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

LIST MEDICATION	DOSE/AMOUNT TAKEN	TIME	WILL MEDICATION BE NEEDED AT SCHOOL?
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

Side effects/reactions: ____

Contraindications for Administration: ____

____

Physician's Signature ____ **Date:** ________________

Print/Stamp physician name, address and phone number: ______________________________________

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Name of Student: ______________________________ School: _________________________ DOB: _____________

EMERGENCY CONTACTS: Name/Relation

1. ____________________________________ Home _____________ Work ______________ Cell _______________

2. ____________________________________ Home _____________ Work ______________ Cell _______________

3. ____________________________________ Home _____________ Work ______________ Cell _______________

Parent/Guardian Permission

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the Cumberland County School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for one year, unless revoked. I give permission to the public health school nurse and other designated staff members of Cumberland County Schools to perform and carry out the tasks as outlined by this Shunt Action Plan. I also consent to the release of the information contained in this Shunt Action Plan to all staff members and other adults who have custodial care of my child and who need to know this information in order to maintain my child's health and safety.

Acknowledged and received by:

Parent/Guardian: ____ Date: ___________________________