Desoto County Schools

Shunt Care Plan

Student:	Parent/Guardian:
Date of Birth:	Home Phone:
Grade: Teacher:	Work Phone:
School:	Cell Phone:

Student Specific Emergencies:

If you see this:	**Do This:**
Headache	Call parents, send home
Vomiting	Call parents, send home If no one contacted within 20 min., call 911
Lethargy (sleepy, groggy)	Call parents, send home
Seizures	Call parents, if seizure lasts over 5 min., call 911
Irritability	Call parents, send home
Swelling along shunt line	Call parents, send home
Decreased school performance	Call parents, send home
Fever	Call parents, send home
Left eye wanders or eyes look down	Call parents

If an emergency is life threatening, immediately have someone call 911 and stay with the student.

Parent/Guardian: Please answer the following questions about your child

1. Reason for shunt: _____
2. Age of child when shunt was first placed: _____
3. Name of doctor and date last visit for shunt: _____
4. Date of last shunt revision: _____
5. Date of next appointment for shunt: _____
6. Medications your child is currently taking (list all)

   _____ _____

   _____ _____

   _____ _____
7. Activity restrictions: _____

   (***Must have physician order to limit PE participation)***

Parent/Guardian Signature: _____ Date: _____