SEIZURE
Individualized Healthcare Plan/Emergency Action Plan

Picture

STUDENT INFORMATION

Student:	**DOB:**	**School/Grade:**	**School Year:**
Parent:	**Phone:**	**Email:**	
Physician:	**Phone:**	**Fax:**	**SMMO** □**Yes** □**No**
School Nurse:	**School Phone:**	**Fax:**	

Background:

SEIZURE INFORMATION

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's reaction to seizure:

Parent: complete the above section, read and sign below, obtain signature from Health Care Provider (if no SMMO) and return to school nurse.

As parent/guardian of the above named student, I give permission for my child's healthcare provider to share information with the school nurse for the completion of this order. I understand the information contained in this order will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, care or medication order. If medication is ordered I authorize school staff to administer medication described below to my child. If prescription is changed a new SMMO must be completed before the school staff can administer the medication. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.

Parent Signature:_____Date:_____

SEIZURE ACTION PLAN - Mark behaviors that apply to student

If you see this	*Do this*	EMERGENCY SEIZURE PROTOCOL	*Expected Behavior after Seizure*
□ Sudden cry or squeal □ Falling down □ Rigidity/Stiffness □ Thrashing/Jerking □ Loss of bowel/bladder control □ Shallow breathing □ Stops breathing □ Blue color to lips □ Froth from mouth □ Gurgling or grunting noises □ Loss of consciousness □ Staring □ Lip smacking □ Eye movement_____ □ Other: _____	**BASIC SEIZURE FIRST AID** ▪ Stay calm & track time ▪ Keep child safe ▪ Do not restrain ▪ Do not put anything in mouth ▪ Stay with child until fully conscious ▪ Protect head ▪ Keep airway open/watch breathing ▪ Turn child on side ▪ Do not give fluids or food during or immediately after seizure	□ Call 911 at _____ minutes for transport to _____ □ Call parent or emergency contact □ Administer emergency medications as indicated on SMMO □ Other_____ **A seizure is generally considered an emergency when:** ▪ Convulsive (tonic-clonic) seizure lasts longer than 5 minutes ▪ Student has repeated seizures with or without regaining consciousness ▪ Student is injured, pregnant or has diabetes ▪ Student has a first-time seizure ▪ Student has breathing difficulties ▪ Student has a seizure in water	▪ Tiredness ▪ Weakness ▪ Sleeping, difficult to arouse ▪ Somewhat confused ▪ Regular breathing ▪ Other: _____ ***Follow Up*** ▪ Notify School Nurse ▪ Document

SPECIAL CONSIDERATIONS

Does the student have a Vagus Nerve Stimulator? ☐ Yes ☐ No
If YES, describe magnet use:

Special considerations and precautions (regarding school activities, sports, trips, helmet, height restriction, etc.):

EMERGENCY SEIZURE RESCUE MEDICATION (See SMMO)

Person to give seizure rescue medication: ☐ School Nurse, ☐ Parent, ☐ EMS, ☐ Volunteer(s) (Specify:)_____ Attach volunteer(s) training documentation ☐ Other:_____

Location of seizure rescue medication (must be locked):

ROUTINE MEDICATIONS

Medication	Dose	Route	Time	Side-Effects

SIGNATURES

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to perform and carry out the tasks as outlined in this Individualized Healthcare Plan (IHP) and for my child's healthcare provider to share information with the school nurse for the completion of this plan. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis. It is the responsibility of the parent/guardian to notify the School Nurse whenever there is any change in the student's health status or care. Parents/Guardian and student are responsible for maintaining necessary supplies, medications and equipment.

School Nurse Signature:_____Date_____
Prescriber Signature (if no SMMO): _____Date:_____
Licensed Trainer Signature (if needed): _____Date:_____