

<b>SEIZURE</b> <b>Individualized Healthcare Plan (IHP)</b> <b>Emergency Care Plan (ECP)</b>	School Year:	Picture
	<b>SMMO</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

**STUDENT INFORMATION**

<b>Student:</b>	<b>DOB:</b>	<b>Grade:</b>	<b>School:</b>
<b>Parent:</b>	<b>Phone:</b>		<b>Email:</b>
<b>Physician:</b>	<b>Phone:</b>		<b>Fax:</b>
<b>School Nurse:</b>	<b>School Phone:</b>		<b>Fax:</b>

**History:**

**SEIZURE INFORMATION**

Seizure Type/Description	Length	Frequency

Seizure triggers or warning signs:

Student's reaction to seizure:

**SPECIAL CONSIDERATIONS**

Special considerations and precautions (regarding school activities, field trips, sports, 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):

**VAGUS NERVE STIMULATOR (VNS) (See SMMO)**

This student has a Vagus Nerve Stimulator:  Yes    No

Location of magnet:

Person(s) trained on magnet use:  School Nurse    Teacher    Aide    Volunteer(s) Specify:  
 Attach volunteer(s) training documentation  Other:

Describe magnet use:

**CONTINUED ON NEXT PAGE**

<b>Student Name:</b>		<b>DOB:</b>
<b>SEIZURE ACTION PLAN – Mark all behaviors that apply to student</b>		
<b>If you see this:</b>		<b>Do this:</b>
<input type="checkbox"/> Sudden cry or squeal <input type="checkbox"/> Falling down <input type="checkbox"/> Rigidity/Stiffness <input type="checkbox"/> Thrashing/Jerking <input type="checkbox"/> Loss of bowel/bladder control <input type="checkbox"/> Shallow breathing <input type="checkbox"/> Stops breathing <input type="checkbox"/> Blue color to lips <input type="checkbox"/> Froth from mouth <input type="checkbox"/> Gurgling or grunting noises <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Staring <input type="checkbox"/> Lip smacking <input type="checkbox"/> Eye movement <input type="checkbox"/> Other: _____		<b>BASIC SEIZURE FIRST AID</b> <ul style="list-style-type: none"> <li>▪ Stay calm &amp; track time</li> <li>▪ Keep child safe</li> <li>▪ Do not restrain</li> <li>▪ Do not put anything in mouth</li> <li>▪ Stay with child until fully conscious</li> <li>▪ Protect head</li> <li>▪ Keep airway open/watch breathing</li> <li>▪ Turn child on side</li> <li>▪ Do not give fluids or food during or immediately after seizure</li> </ul>
<b>EMERGENCY SEIZURE PROTOCOL</b>		<b>Expected Behavior after Seizure</b>
<input type="checkbox"/> Call 911 at ____ minutes for transport to: _____ <input type="checkbox"/> Call parent or emergency contact <input type="checkbox"/> Administer emergency medications as indicated on SMMO <input type="checkbox"/> Oxygen <input type="checkbox"/> Other (specify): _____ <b>A seizure is generally considered an emergency when:</b> <ul style="list-style-type: none"> <li>▪ Convulsive (tonic-clonic) seizure lasts longer than 5 minutes</li> <li>▪ Student has repeated seizures with or without regaining consciousness</li> <li>▪ Student is injured, pregnant or has diabetes</li> <li>▪ Student has a first-time seizure</li> <li>▪ Student has breathing difficulties</li> <li>▪ Student has a seizure in water</li> </ul>		<ul style="list-style-type: none"> <li>▪ Tiredness</li> <li>▪ Weakness</li> <li>▪ Sleeping, difficult to arouse</li> <li>▪ Somewhat confused</li> <li>▪ Regular breathing</li> <li>▪ Other: _____</li> </ul>
		<b>Follow-Up</b>
		<ul style="list-style-type: none"> <li>• Notify School Nurse</li> <li>• Document!</li> </ul>
<b>SIGNATURES</b>		
<p>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 plan of care. I understand 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 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.</p>		
Parent Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:
<b>SCHOOL NURSE</b>		
Seizure Emergency Care Plan (this form) distributed to ‘need to know’ staff:		
<input type="checkbox"/> Front office/admin <input type="checkbox"/> Teacher(s) <input type="checkbox"/> Transportation <input type="checkbox"/> Other (specify): _____		
School Nurse Signature:		Date: