

SEIZURE ACTION PLAN Simplified Individualized Healthcare Plan (IHP) Emergency Action Plan (EAP) Utah Department of Health & Human Services/ Utah State Board of Education			School Year:	Picture
			SMMO <input type="checkbox"/> Yes <input type="checkbox"/> No	
STUDENT INFORMATION				
Student:	DOB:	Grade:	School:	
Parent:	Phone:		Email:	
Physician:	Phone:		Fax:	
School Nurse:	School Phone:		Fax:	
History:				
SECTION 504 PLAN				
Students with epilepsy or seizure disorder may also need a separate Section 504 plan in place to provide accommodations necessary to access their education.				
SEIZURE INFORMATION				
Seizure Type/Description		Length	Frequency	
Seizure triggers or warning signs:				
Student specific information:				
SPECIAL CONSIDERATIONS				
Special considerations and precautions (regarding school activities, field trips, sports, etc):				
EMERGENCY SEIZURE RESCUE MEDICATION (SMMO required)				
Person to give seizure rescue medication: <input type="checkbox"/> School Nurse <input type="checkbox"/> Parent <input type="checkbox"/> EMS <input type="checkbox"/> Volunteer (specify): _____ <input type="checkbox"/> Other (specify): _____ Attach volunteer(s) training documentation				
Location of seizure rescue medication (must be locked but accessible):				
IMPLANTED DEVICES (Provider order not required)				
This student has the following device: <input type="checkbox"/> Responsive Neurostimulation (RNS) - <i>no action required by staff.</i> <input type="checkbox"/> Deep Brain Stimulation (DBS) - <i>no action required by staff.</i> <input type="checkbox"/> Vagus Nerve Stimulator (VNS) - <i>swipe magnet across left side of chest, over VNS battery, counting "one-one thousand, two-one thousand". Wait one minute and repeat as needed for seizure activity.</i>				
Location of magnet (where in the school):				
Person(s) trained on magnet use: <input type="checkbox"/> School Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Aide <input type="checkbox"/> Volunteer (specify): _____ <input type="checkbox"/> Other (specify): _____ Attach volunteer(s) training documentation				
CONTINUED ON NEXT PAGE				

Seizure Action Plan

Student Name:		DOB:	School Year:
SEIZURE ACTION PLAN – Mark all behaviors that apply to student			
If you see this:		Do this:	
<input type="checkbox"/> Sudden cry or squeal <input type="checkbox"/> Loss of bowel or bladder control <input type="checkbox"/> Staring <input type="checkbox"/> Rhythmic eye movement <input type="checkbox"/> Lip smacking <input type="checkbox"/> Gurgling or grunting noises <input type="checkbox"/> Falling down <input type="checkbox"/> Rigidity or stiffness <input type="checkbox"/> Thrashing or jerking <input type="checkbox"/> Change in breathing <input type="checkbox"/> Blue color to lips <input type="checkbox"/> Froth from mouth <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Other (specify):		<input type="checkbox"/> Stay calm & track time <input type="checkbox"/> Report symptoms and duration to parent <input type="checkbox"/> Keep student safe <input type="checkbox"/> Do not restrain <input type="checkbox"/> Protect head <input type="checkbox"/> Keep airway open/watch breathing <input type="checkbox"/> Turn student on side <input type="checkbox"/> Do not put anything in mouth <input type="checkbox"/> Do not give fluids or food during or immediately after seizure <input type="checkbox"/> Stay with student until fully conscious <input type="checkbox"/> Ensure symptoms resolve before student leaves classroom <input type="checkbox"/> Swipe VNS magnet (if applicable) <input type="checkbox"/> Other (specify):	
Expected Behavior after Seizure		EMERGENCY SEIZURE PROTOCOL	
<ul style="list-style-type: none"> ▪ Tiredness ▪ Weakness ▪ Sleeping, difficult to arouse ▪ Somewhat confused ▪ Regular breathing ▪ Other (specify): <p>Follow-Up</p> <ul style="list-style-type: none"> • Notify school nurse • Document observations 		<input type="checkbox"/> Call EMS at _____ minutes for transport to: _____ hospital <input type="checkbox"/> Call parent or emergency contact <input type="checkbox"/> Administer emergency medications and/or oxygen as indicated on SMMO <input type="checkbox"/> Other (specify):	
		<p>A seizure is generally considered an emergency when:</p> <ul style="list-style-type: none"> ▪ Convulsive (tonic-clonic) seizure lasts longer than 5 minutes ▪ Repeated seizures with or without regaining consciousness ▪ Breathing difficulties continue after seizure ▪ Seizure occurs in water 	
SIGNATURES			
As parent/guardian of the above named student, I give permission for my student’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. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.			
Parent Name (print):		Signature:	Date:
Emergency Contact Name:		Relationship:	Phone:
SCHOOL NURSE			
Seizure Emergency Action 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:

Addendum: