

SEIZURE Individualized Healthcare Plan/Emergency Action Plan				Picture
STUDENT INFORMATION				
Student:	DOB:	School/Grade:	School Year:	
Parent:	Phone:	Email:		
Physician:	Phone:	Fax:	SMMO <input type="checkbox"/> Yes <input type="checkbox"/> 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	
<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: _____	BASIC SEIZURE FIRST AID <ul style="list-style-type: none"> ▪ 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 	<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"/> Other _____ A seizure is generally considered an emergency when: <ul style="list-style-type: none"> ▪ 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 	<ul style="list-style-type: none"> ▪ Tiredness ▪ Weakness ▪ Sleeping, difficult to arouse ▪ Somewhat confused ▪ Regular breathing ▪ Other: _____ 	
SPECIAL CONSIDERATIONS				
Does the student have a Vagus Nerve Stimulator? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> School Nurse, <input type="checkbox"/> Parent, <input type="checkbox"/> EMS, <input type="checkbox"/> Volunteer(s) (Specify): _____ Attach volunteer(s) training documentation <input type="checkbox"/> 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: _____				

