SEIZURE **Individualized Healthcare Plan (IHP)** **Emergency Care Plan (ECP)** **SMMO:** ☐ Yes ☐ No	 Nursing & Health Services Phone 435-752-3925 Fax 435-792-7796	**ATTACH STUDENT PHOTO**

STUDENT INFORMATION

Student:	DOB:	School:	Grade:	Year:
Parent:	Phone:		Email:	
Physician:	Phone:		Fax:	
School Nurse:	Phone:		Email:	

HISTORY

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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 and Description	Length	Frequency

SEIZURE TRIGGERS OR WARNING SIGNS

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STUDENT SPECIFIC INFORMATION

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SPECIAL CONSIDERATIONS AND PRECAUTIONS REGARDING SCHOOL ACITIVTIES, FIELD TRIPS, SPORTS, ETC.

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EMERGENCY SEIZURE RESCUE MEDICATION (See SMMO)

Person to give seizure rescue medication: ☐ School Nurse ☐ Parent ☐ EMS ☐ Volunteer(s) ☐ Other: __________
ATTACH volunteer(s) training documentation

LOCATION OF SEIZURE RESCUE MEDICATION (MUST BE LOCKED but)

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IMPLANTED DEVICES

This student has the following device:
☐ Responsive Neurostimulation (RNS). No action required by staff.
☐ Deep Brain Stimulation (DBS). No action require by staff.
☐ Vagus Nerve Stimulator (VNS)

- Location of magnet (where in the school):
- Describe magnet use and location of implanted device:

Person(s) trained on magnet use: ☐ School Nurse ☐ Teacher ☐ Volunteer(s) ☐ Other: ________________
ATTACH volunteer(s) training documentation

CONTINUED ON NEXT PAGE

Student Name:	DOB:

SEIZURE ACTION PLAN – Check all behaviors that apply to student

IF YOU SEE THIS	DO THIS (BASIC SEIZURE FIRST AID)
☐ Blue color to lips ☐ Change in breathing ☐ Falling down ☐ Froth from mouth ☐ Gurgling or grunting noises ☐ Lip smacking ☐ Loss of bowel/bladder control ☐ Loss of consciousness ☐ Rhythmic Eye movement ☐ Rigidity/Stiffness ☐ Staring ☐ Sudden cry or squeal ☐ Thrashing/Jerking ☐ Other: ____________________________	▪ Stay calm and track time ▪ Report symptoms and duration to parent ▪ Keep student safe ▪ Do not restrain ▪ Protect head ▪ Keep airway open ▪ Monitor breathing ▪ Turn child on side ▪ Do not give fluids or food during or immediately after seizure ▪ Stay with student until fully conscious ▪ Ensure symptoms resolve before student leaves classroom ▪ Swipe VNS magnet (if applicable) ▪ Other:

EMERGENCY SEIZURE PROTOCOL	EXPECTED BEHAVIORS AFTER SEIZURE
☐ Call 911 (EMS) at _______ minutes ☐ Call parent or emergency contact ☐ Administer emergency medications as indicated on SMMO ☐ Administer Oxygen if ordered ☐ Other (specify):	▪ Tiredness ▪ Weakness ▪ Sleepy, difficult to arouse ▪ Somewhat confused ▪ Regular breathing ▪ Other:_________________________________ ____ ____
A Seizure is generally considered an Emergency when	**FOLLOW-UP**
▪ Convulsive (tonic-clonic) seizure lasts longer than 5 minutes ▪ Repeated seizures with or without regaining consciousness ▪ Breathing difficulties continue after seizure ▪ Student is injured, pregnant or has diabetes ▪ Seizure occurs in water ▪ Student has a first-time seizure	▪ Notify School Nurse ▪ Document

SIGNATURES

As parent/guardian of the above-named student, I give permission for my child's healthcare provider to share information with the District 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 District 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. Parent/Guardian is responsible for maintaining necessary supplies, medications and equipment. **This document is not valid and no specific accommodations will be made until signed by all parties.**

Parent Signature:		Date:
ER Contact Name:	Relationship:	Phone:

This health care plan is to be distributed via PowerSchool or as needed by **front office** to all "need to know" staff.

Health Care Provider Signature:	Date:
District Nurse Signature:	Date: