SEIZURE INDIVIDUAL HEALTH PLAN

(Parent/guardian to complete this form)

STUDENT NAME ______________________ DOB __________ SCHOOL ________________

GRADE ________ TEACHER ______________________ SCHOOL YEAR ________________

PARENT/GUARDIAN ____________________ BEST CONTACT/PHONE NUMBER ____________

PHYSICIAN ______________________________ PHONE ____________________

NEUROLOGIST ____________________________ PHONE ____________________

Please describe what usually happens during and after your child's seizure(s):

How often does your child have seizures?

How long do they usually last?

What triggers or causes the seizure(s)?

Does your child have an aura or warning of an on-coming seizure? ☐ Yes ☐ No If yes, please describe:

Are they able to notify anyone of an on-coming seizure? ☐ Yes ☐ No

Does your child take a medication at home every day to keep their seizures controlled? ☐ Yes ☐ No
If yes, what medication?

Does your child have a doctor's order for emergency medication for a seizure to be given at school, like Diastat, and is the medication at school? ☐ Yes ☐ No

Does your child have a Vagus Nerve Stimulator (VNS)? ☐ Yes ☐ No

In the event that you cannot be reached, please list the name(s) and phone number(s) of persons who are familiar with your child's seizures and have knowledge of how to manage a seizure. *Please also add this person(s) to your child's pickup list in case they may need to pick your child up from school due to their seizures.*

Name: ____________________ Phone Number: ______________

Name: ____________________ Phone Number: ______________

Is there anything else you would like school staff to know about your child's seizures?

PLEASE NOTE: We recommend an Emergency Action Plan, completed by a doctor, for all children with seizures. Please review the back of this form for steps school staff may take in the event of a medical emergency. These will be followed if your child does not have an Emergency Action Plan at school for this condition.

☐ I give permission for my child, ______________________, to receive care for the medical condition listed above by designated school staff.

☐ School nurse may share information regarding this condition with my child's doctor.

PARENT/GUARDIAN SIGNATURE ______________________ DATE ____________

SCHOOL NURSE SIGNATURE ________________________ DATE ____________

SEIZURE INDIVIDUAL HEALTH PLAN

Emergency: Seizure

STUDENT NAME ______________________

SEIZURE TRIGGERS ______________________

Note: If student also has an Emergency Action Plan (EAP) for this condition, please refer to the EAP for actions school staff should take instead. Otherwise, follow the steps below.

This student has an EAP: ☐ Yes ☐ No

Symptoms:

☐ Staring
☐ Jerking movements of the arms and legs
☐ Stiffening of the body
☐ Loss of consciousness
☐ Breathing problems or breathing stops
☐ Loss of bowel or bladder control
☐ Falling suddenly for no apparent reason
☐ Not responding to noise or words for brief periods
☐ Appearing confused or in a haze
☐ Nodding head
☐ Periods of rapid eye blinking and staring
☐ Lips may become bluish
☐ Other: ______________________

Interventions:

1. Stay with student; student should not leave location or be left alone.
2. Assist student to horizontal position and turn onto side as soon as able (into recovery position).
3. Call 911. Notify front office to direct EMS to student's location.
4. Clear area around student of objects and people. Do not restrain student's movement or place anything in mouth. Remove glasses if wearing and loosen clothing around neck.
5. Note time seizure started and stopped, if able, and observations of what the seizure looked like.
6. Call or radio for help. Designated first responder school staff should respond to the student's location, and bring any needed emergency equipment.
7. Notify parents/guardians, or designate another staff member to notify:
   Parent/guardian name: ______________ Phone number: ______________
   Emergency contact name: ______________ Phone number: ______________
8. Notify school nurse, if in building. If school nurse is not present, notify upon return or via other communication.

Additional information:

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Reference: https://www.chop.edu/conditions-diseases/seizures-and-epilepsy

Seizure Emergency Action Plan

Student: ____________________ DOB: ___________ Grade: _____ Classroom/Homeroom: ______________

Parent/Guardian: ____________________ Phone (c): _____________ (h): ______________ (w): ______________
Parent/Guardian: ____________________ Phone (c): _____________ (h): ______________ (w): ______________
Physician: ______________________ Phone: __________________ Fax: _________________

SEIZURE INFORMATION			
Seizure type	Length	Frequency	Description
Seizure triggers or warning signs:			Response after seizure:
Daily medications (see below for emergency medications):			Dietary adjustments due to medication (complete diet order if needed):
Special considerations and precautions:			

TREATMENT	
☐ **Absence** ☐ **Atonic** ☐ **Focal impaired awareness (Complex partial)** ☐ **Infantile spasms**	1. Stay with the student during and after the seizure. Although the student may appear conscious, they may lose awareness of surroundings. 2. Be prepared to assist student to the floor if they lose consciousness. 3. Time seizure(s) and watch for clusters. 4. Document seizure in log. 5. Notify parent/guardian. **Special Instructions:** ______________________________
☐ **Tonic-clonic**	1. Do not restrain movement. Let the seizure run its course. 2. Turn student on side. Loosen the student's collar. 3. Do not place anything in the mouth. Remove hard, sharp objects from the area. 4. If possible, turn student's head to the side in the event student vomits. (Use "Universal Precautions" if student vomits.) 5. Observe, note time, and be prepared to describe the pattern of the seizure. 6. Record details as they occur or as soon as possible thereafter. 7. Notify parent/guardian. 8. When seizure is over, allow the student to rest. 9. Stay with the student until fully recovered or parent/guardian arrives.
Administer Emergency Medication:	**Diastat Order:** _______ Per rectum for seizure lasting ____ minutes or ___ or more seizures in a row. **Other Emergency Medication Order:** (Order will be reviewed for ability to administer at school) ______________________________ **Vagus Nerve Stimulator?** ☐ Yes ☐ No If **Yes**, Location of VNS: ___________________ Swipe after _________ minutes Repeat swipe if: ______________________ (Include maximum number of times to swipe)
Call 911	**Call 911** if: Diastat or Versed given and/or : • The seizure lasts more than _______ minutes • The student has a continuous seizure, or cluster of ≥ ____seizures • The student remains unconscious after the seizure • The student is having difficulty breathing • Any injury resulted from the seizure. • ______________________________
Activity Instructions	**OK to swim?** ☐ **no** ☐ yes ☐ needs to wear life vest ☐ needs one on one supervision **Other:** ______________________________

Physician's signature: ______________________________ Date: ____________

I give permission to school staff to give the medication listed above as instructed, and to contact MD for questions. My preferred method of notification is: ____ Phone ____ Email ____ Other

Parent/Guardian Signature: ______________________________ Date: _____________

Reviewed by School Health Nurse: ___________________________ Date: _____________

Rev. 2-10-20