

SEIZURE Individualized Healthcare Plan (IHP) Emergency Care Plan (ECP)	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:

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

Student Name:		DOB:
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"/> 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
EMERGENCY SEIZURE PROTOCOL		Expected Behavior 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"/> Oxygen <input type="checkbox"/> Other (specify): _____ 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: _____
		Follow-Up
		<ul style="list-style-type: none"> • Notify School Nurse • Document!
SIGNATURES		
<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:
SCHOOL NURSE		
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: