SEIZURE

Individualized Healthcare Plan (IHP)
Emergency Action Plan (EAP)
Utah Department of Health/Utah Board of Education/OSD

School Year:	Picture
SMMO ☐ **Yes** ☐ **No**	

STUDENT INFORMATION

Student:	DOB:	Grade:	School:
Parent:	Phone:		Email:
Physician:	Phone:		Fax:
School Nurse:	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) NA

Person to give seizure rescue medication: ☐ School Nurse ☐ Parent ☐ EMS ☐ Volunteer(s) Specify
☐ Other:

Location of seizure rescue medication (must be locked):

VAGUS NERVE STIMULATOR (VNS) (See SMMO) NA

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: training ☐ 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:***
☐ Sudden cry or squeal	☐ Gurgling or grunting noises	BASIC SEIZURE FIRST AID
☐ Falling down	☐ Rigidity/Stiffness	• Stay calm & track time
☐ Thrashing/Jerking	☐ Eye movement	• Keep child safe
☐ Loss of bowel/bladder control	☐ Staring	• Do not restrain
☐ Shallow breathing	☐ Lip smacking	• Do not put anything in mouth
☐ Stops breathing		• Stay with child until fully conscious
☐ Blue color to lips		• Protect head
☐ Froth from mouth		• Keep airway open/watch breathing
☐ Loss of consciousness		• Turn child on side
☐ Other:		• Do not give fluids or food during or immediately after seizure
		• Other:

EMERGENCY SEIZURE PROTOCOL	***Expected Behavior after Seizure***
☐ Call 911 at ___ minutes for transport to:________________	• Tiredness
☐ Call parent or emergency contact	• Weakness
☐ Administer emergency medications as indicated on SMMO	• Sleeping, difficult to arouse
☐ Oxygen	• Somewhat confused
☐ Other:	• Regular breathing
A seizure is generally considered an emergency when:	• Other:
• Convulsive (tonic-clonic) seizure lasts longer than 5 minutes	**Follow-Up**
• Student has repeated seizures with or without regaining consciousness	
• Student is injured, pregnant or has diabetes	• Notify School Nurse (Use Seizure Log Sheet)
• Student has a first-time seizure	• Document! (Use Seizure Log Sheet)
• Student has breathing difficulties	
• Student has a seizure in water	

PARENT SIGNATURE

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.

Parent Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:

PHYSICIAN SIGNATURE

As the student's LIP I confirm that the student has a diagnosis of seizures and the above plan is appropriate for school.

Physician Signature:	***Date:***

SCHOOL NURSE SIGNATURE

Seizure Emergency Action Plan (this form) distributed to 'need to know' staff: ☐ Front office/admin ☐ Teacher(s) ☐ Transportation ☐ Other (specify):

School Nurse Signature:	Date: