SEIZURE
Individualized Healthcare Plan/Emergency Action Plan

Picture

STUDENT INFORMATION

Student:	**DOB:**	**School/Grade:**	**School Year:**
Parent:	**Phone:**	**Email:**	
Physician:	**Phone:**	**Fax:**	**SMMO** ☐**Yes** ☐**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*
☐ Sudden cry or squeal ☐ Falling down ☐ Rigidity/Stiffness ☐ Thrashing/Jerking ☐ Loss of bowel/bladder control ☐ Shallow breathing ☐ Stops breathing ☐ Blue color to lips ☐ Froth from mouth ☐ Gurgling or grunting noises ☐ Loss of consciousness ☐ Staring ☐ Lip smacking ☐ Eye movement_____ ☐ Other: _____	**BASIC SEIZURE FIRST AID** ▪ 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	☐ Call 911 at _____ minutes for transport to _____ ☐ Call parent or emergency contact ☐ Administer emergency medications as indicated on SMMO ☐ Other_____ **A seizure is generally considered an emergency when:** ▪ 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	▪ Tiredness ▪ Weakness ▪ Sleeping, difficult to arouse ▪ Somewhat confused ▪ Regular breathing ▪ Other: _____ ***Follow Up*** ▪ Notify School Nurse ▪ Document

SPECIAL CONSIDERATIONS

Does the student have a Vagus Nerve Stimulator? ☐ Yes ☐ 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: ☐ School Nurse, ☐ Parent, ☐ EMS, ☐ Volunteer(s) (Specify:)_____ Attach volunteer(s) training documentation ☐ 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:_____

SEIZURE Medication/Management Orders (SMMO) Utah Department of Health/Utah State Board of Education In Accordance with UCA 53A-11-603.5	PCH Pediatric Neurology Clinic 801-213-3599 Fax: 801-587-7539	Other provider:

STUDENT INFORMATION			
Student:	**DOB:**	**Grade:**	**School:**
Parent:	**Phone:**		**Email:**
Physician:	**Phone:**		**Fax:**
School Nurse:	**School Phone:**		**Fax:**

SEIZURE INFORMATION		
Seizure Type/Description	**Length**	**Frequency**

If Seizures are full body tonic-clonic, rescue medication may be administered by a trained volunteer.
Seizures other than tonic-clonic, rescue medication can only be given by an RN, Parent or EMS.

☐ Yes ☐ No Student has received a first dose of this medication in a non-medically-supervised setting without a complication.

If No, medication cannot be given by a trained volunteer. Can only be given by an RN, parent, or EMS.

☐ Yes ☐ No Student has previously ceased having a full body prolonged or convulsive seizure as a result of receiving this medication.

If No, medication cannot be given by a trained volunteer. Can only be given by an RN, parent, or EMS.

Parent: complete the above section, read and sign below, obtain signature from Health Care Provider, 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:

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Student Name:	DOB:

EMERGENCY SEIZURE RESCUE MEDICATION

To Be Completed by Prescriber - In accordance with these orders, an Individualized Health Care Plan (IHP) must be developed by the School Nurse and parent to be shared with appropriate school personnel, *and cannot be shared with any individual outside of those public education employees without parental consent.* As the student's LIP I confirm that the student has a diagnosis of seizures.

Give Emergency Medication IF:	Medication	Dose	Route	Call
• If seizure lasts ___ minutes or greater • If ___ or more consecutive seizures with or without a period of consciousness (in ___ minutes) • Other_____	□ Midazolam (Versed) (Dose must be provided in 2 syringes) □ Diazepam (Diastat) □ Other _____	_____ mg _____ ml	□ Nasal □ Rectal □ Other	**ALWAYS call 911, parent and School Nurse**

☐ This medication is necessary during the school day. Trained personnel should and will be allowed to administer this medication.

Common potential side effects: respiratory depression, nasal irritation, memory loss, drowsiness, other:

Additional instructions for administration:

VAGUS NERVE STIMULATOR

☐ This student has a Vagus Nerve Stimulator. Trained personnel should and will be trained on magnet use. Describe magnet use:

PRESCRIBER SIGNATURE

This order can only be signed by an MD/DO; Nurse Practitioner, Certified Physician's Assistant or a provider with prescriptive practice.

Prescriber Name:	Phone:
Prescriber Signature:	Date:
School Nurse Signature:	Date: