INDIVIDUALIZED HEALTHCARE PLAN
SEIZURE

Healthcare Plan effective for the current school year, including summer school

Student Name:	Date of Birth:	Grade:

SEIZURE HISTORY

To be completed by Licensed Healthcare Provider (Physician, Physician's Assistant or Nurse Practitioner):

Seizure Type (check all that apply):	Description: Location, frequency, duration	Describe a "seizure emergency" for this student:
Primary Generalized Seizure: ☐ Tonic/Clonic Seizures ☐ Absence Seizures ☐ Myoclonic Seizures ☐ Atonic Seizures Partial Seizure: ☐ Simple Partial Seizure ☐ Complex Partial Seizure		

Seizure triggers or warning signs:	Student's response after a seizure:

Student will be monitored for seizure activity. At the onset of seizure activity, refer to the following instructions:

BASIC SEIZURE FIRST AID:

DO NOT REMOVE STUDENT FROM AREA unless student is in an unsafe environment

- Stay calm and track time
- Keep child safe; position on side; place something soft under the head; remove other students from the immediate area
- Notify school nurse
- **Do not restrain**
- **Do not put anything in mouth**
- Stay with child until fully conscious
- For tonic-clonic (grand mal) seizure:
- Protect head, turn child on side
- Keep airway open/watch breathing

SEIZURE EMERGENCY PROTOCOL:

- School nurse/trained designee to administer emergency medications as indicated below
- If student stops breathing and/or has no pulse – **BEGIN CPR**
- Call 911 for transport to hospital for seizure lasting longer than _____ minutes
- **NOTE: If time is not indicated, 911 will be called for seizure lasting 5 minutes or longer.**
- Notify parent or emergency contact at these phone numbers:
  ____
  ____

Other:

Call 911 if:

Student has seizure lasting longer than 5 minutes (unless specified in **EMERGENCY PROTOCOL**)
Student has repeated seizures (seizure stops and starts again)
Student cannot be awakened after seizure
Student has breathing difficulties
Diastat is administered
Student has diabetes
Student is injured during seizure
Student is pregnant

Emergency Medication/Treatment		Dose	Instructions
Rectal Diazepam/Diastat	☐ Yes ☐ No		
Vagus Nerve Stimulator	☐ Yes ☐ No		Describe magnet use:
VP Shunt	☐ Yes ☐ No	N/A	
Other:			

After a seizure:

- Place student on side to allow drainage of secretions and monitor breathing.
- Remain with student until he/she has regained pre-seizure mental and physical senses and is oriented to surroundings.
- Provide privacy and allow student to rest.
- Do not give food or drink until fully awake.
- Inform parent, clinic and EMS personnel (if called) of observed seizure, medication given and post-seizure activity

______________________ ______________________ __________ ______________

Licensed Healthcare Provider Name (PRINT) **Licensed Healthcare Provider Signature** **Date** **Phone Number**

To be Reviewed and Signed by PARENT/GUARDIAN:

Does this student's Diastat need to be with the student: Check all 3 columns to the **right (Note: if "No" is checked, medication will be kept in the school clinic during the school day)**	In the classroom?	☐ Yes	☐ No
	On the bus/transportation vehicle?	☐ Yes	☐ No
	On community outings during the school day?	☐ Yes	☐ No

I have reviewed this health plan and agree to the contents. I give my permission for appropriately trained Northstar Academy and/or Career Academy staff to administer the above medications to my child as ordered by the prescriber. I hereby release Northstar Academy and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance. School staff and/or the school nurse may communicate with the Licensed Healthcare Provider/medical office staff about this IHP. I will provide the school with all medication ordered in this plan for my child in the original container provided by the pharmacy.

______________________ ______________________ __________ ______________

Parent/Guardian Name (print) **Parent/Guardian Signature** **Date** **Phone Number**

School Nurse Signature:	***Date Received:***