SEIZURE Individualized Healthcare Plan (IHP) Emergency Care Plan (ECP)	School Year:	Picture
	SMMO **□Yes □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:***
□ 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
EMERGENCY SEIZURE PROTOCOL	***Expected Behavior after Seizure***
□ Call 911 at ____ minutes for transport to:_____ □ Call parent or emergency contact □ Administer emergency medications as indicated on SMMO □ Oxygen □ Other (specify): **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!

SIGNATURES

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:

SCHOOL NURSE

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

School Nurse Signature:	Date: