

Individual Health Plan - Seizure Management _____ **Date of IHP** _____

Student Name _____ ID# _____ HR/Team _____ Bus#/Car _____

Specified Seizure Description _____

Seizure last occurred on (date) _____ and appeared as (description) _____

Other Significant Medical History _____

Medications given at home _____

Medications ordered for school hours: _____

First Responders to Seizure Activity should:

- Track the time of seizure onset and duration of seizure symptoms.
- Remove objects surrounding student.
- Avoid restraining student or putting anything in student’s mouth.
- Turn student to side-lying position if possible in case of vomiting.
- Observe breathing and ensure that airway is open.
- Request that another adult contact the building clinic and clear other students from the room.

Building nurses responding to a report of student seizure activity will:

- Review details of seizure occurrence with first responders.
- Verify student’s physician orders for administration of emergency medication if applicable.
- Phone 911 if emergency medication is administered.
- Ensure that student’s parent has been notified of seizure occurrence and 911 call if applicable.
- Notify building and district administration of 911 call.

Emergency (911) Response is appropriate when:

- Seizure duration is greater than 5 minutes or as indicated by Physician on Medication Dispensing Form (MCS-202)
- Repetitive or clustered seizures occur in an unconscious person.
- There is no known history of seizure disorder.
- Seizure is secondary to an injury or other medical condition.
- Breathing impairment accompanies seizure activity.

Signature of person completing form _____ **Date** _____

CLINIC USE ONLY: To be filled out by Building RN

Medication _____ Date Rec. _____ Location(s) _____ Expires _____

Medication _____ Date Rec. _____ Location(s) _____ Expires _____

Is medication carried on the bus? Yes _____ No _____ *(Must have an aide to be able to carry on the bus)*

Does student have a bus aide? Yes _____ No _____ Date of bus aide training _____ Initials _____

Teacher/Appropriate staff copy of IHP	Date:	Initials:
Transportation copy of IHP	Date:	Initials: