SUMNER COUNTY SCHOOLS
SEIZURE IHP/SAFETY PLAN-PRESCRIPTION
MEDICATION ORDERS

Student Name:_____ Birth Date: _____

Address:_____Age:_____ Grade:_____ Teacher: _____

Parent/Guardian:_____ Phone: _____

Emergency Contact/Relationship_____ Phone: _____

Neurologist/Provider:_____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Seizure Type	How Long It Lasts	How Often	What Happens

Signs and Symptoms: Please circle the symptom(s) that occur in your child

- Aura (symptoms before seizing)
- Generalized convulsions involving entire body
- Pallor or skin discoloration
- Labored (noisy) breathing
- Dilation of pupils
- Loss of consciousness (may fall to ground)
- Involuntary loss of urine or feces
- Staring/blank gaze/daydreaming
- Other_____

Is your child aware of impending seizure activity YES NO

FIRST AID FOR ANY SEIZURE	WHEN TO CALL 911
• **STAY** calm, keep calm, **begin timing seizure**	• Seizure with loss of consciousness longer than 5 minutes, not responding to rescue medications
• Keep student **SAFE** remove harmful objects, don't restrain, protect head	• Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue medication if available
• **SIDE-**turn on side if not awake, keep airway clear, don't put objects in mouth	• Difficulty breathing after seizure
• **STAY** until recovered from seizure	• Serious injury occurs or suspected, seizure in water
• Swipe magnet for VNS (if applicable)	• Change in seizure type, number, or pattern
Notify parent if seizure is different from usual type and/or 911 is called.	

911 will be called at **NURSE DISCRETION**, if no rescue medication is available, or if no trained personnel are available.

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the health care provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Sumner County School System, the undersigned parent or guardian hereby understands and agrees that the Sumner County School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication (T.C.A. § 49-5-415). By signing, parent indicates agreement with the plan of action as described by health care provider.

❑ Student information was requested from the parent with no response. This IHP was developed by the school nurse without input from the parents.

Parent/Guardian Signature:_____ Date:_____

School Nurse Signature:_____ Date:_____

BACK PORTION TO BE COMPLETED BY MEDICAL PROVIDER

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Medical Provider Portion

Student Name:_____**Date of Birth**:_____

Rescue Medication Instructions

If seizure (cluster, # or length) _____

Name of Med/RX_____ How much to give (dose) _____

How/When to give _____

Care After Seizure

What type of help is needed?(describe) _____

When is student able to resume usual activity? _____

Daily Medication

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other Information

Triggers: _____

Important Medical History: _____

Allergies: _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted: _____

Diet Therapy: ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Provider Signature: _____ Date: _____

Provider Name (print): _____ Phone: _____