

SEIZURE School Health Plan (SHP) Emergency Action Plan (EAP)		PHOTO	 NURSING & HEALTH SERVICES Phone 435-752-3925 Fax 435-792-7796	RN Approval Date:	
SMMO: ☐ Yes ☐ No					
STUDENT INFORMATION					
Student:	DOB:	School:	Grade:	Year:	
Parent:	Phone:	Email:			
Physician:	Phone:	Email:			
School Nurse:	Phone:	Email:			
HISTORY					
SECTION 504 PLAN					
Students with epilepsy or seizure disorder may also need a separate Section 504 plan in place to provide accommodations necessary to access their education.					
SEIZURE INFORMATION					
Seizure Type and Description		Length	Frequency		
SEIZURE TRIGGERS OR WARNING SIGNS					
STUDENT SPECIFIC INFORMATION					
SPECIAL CONSIDERATIONS AND PRECAUTIONS REGARDING SCHOOL ACITIVITIES, FIELD TRIPS, SPORTS, ETC.					
EMERGENCY SEIZURE RESCUE MEDICATION (See SMMO)					
Person to give seizure rescue medication: ☐ School Nurse ☐ Parent ☐ EMS ☐ Volunteer(s) ☐ Other: _____					
ATTACH volunteer(s) training documentation					
LOCATION OF SEIZURE RESCUE MEDICATION (MUST BE LOCKED but)					
IMPLANTED DEVICES					
This student has the following device: ☐ Responsive Neurostimulation (RNS). No action required by staff. ☐ Deep Brain Stimulation (DBS). No action required by staff. ☐ Vagus Nerve Stimulator (VNS) – swipe magnet across left side of chest, over VNS battery, counting “one-one thousand, two-one thousand, three-one thousand”. Wait one minute & repeat as needed for seizure activity. Location of magnet (where in the school): Describe magnet use and location of implanted device:					
Person(s) trained on magnet use: ☐ School Nurse ☐ Teacher ☐ Volunteer(s) ☐ Other: _____					
ATTACH volunteer(s) training documentation					

Student Name:		DOB:	
SEIZURE ACTION PLAN – Check all behaviors that apply to student			
IF YOU SEE THIS		DO THIS (BASIC SEIZURE FIRST AID)	
☐ Blue color to lips ☐ Change in breathing ☐ Falling down ☐ Froth from mouth ☐ Gurgling or grunting noises ☐ Lip smacking ☐ Loss of bowel/bladder control ☐ Loss of consciousness ☐ Rhythmic Eye movement ☐ Rigidity/Stiffness ☐ Staring ☐ Sudden cry or squeal ☐ Thrashing/Jerking ☐ Other: _____		☐ Stay calm and track time ☐ Report symptoms and duration to parent ☐ Keep student safe ☐ Do not restrain ☐ Protect head ☐ Keep airway open ☐ Monitor breathing ☐ Turn child on side ☐ Do not give any fluids or food or put anything in mouth during or immediately after a seizure ☐ Stay with student until fully conscious ☐ Ensure symptoms resolve before student leaves classroom ☐ Swipe VNS magnet (if applicable) ☐ Other: _____	
EMERGENCY SEIZURE PROTOCOL		EXPECTED BEHAVIORS AFTER SEIZURE	
☐ Call 911 (EMS) at _____ minutes ☐ Call parent or emergency contact ☐ Administer emergency medications as indicated on SMMO ☐ Administer Oxygen if ordered ☐ Other (specify): _____		☐ Tiredness ☐ Weakness ☐ Sleepy, difficult to arouse ☐ Somewhat confused ☐ Regular breathing ☐ Other: _____ _____ _____ _____	
A seizure is considered an emergency & 911 will be called when:			
☐ Convulsive (tonic-clonic) seizure lasts longer than 5 minutes ☐ Repeated seizures with or without regaining consciousness ☐ Breathing difficulties continue after seizure ☐ Student has a first-time seizure ☐ Student is injured, pregnant or has diabetes ☐ Seizure occurs in water		FOLLOW-UP ☐ Notify School Nurse ☐ Document	
PARENT STATEMENT & SIGNATURE			
I authorize my child to receive specified procedures at school as directed by the healthcare provider and/or agreed upon with the District RN. As the parent/guardian of the above-named student, I authorize District RN(s) and trained, designated unlicensed staff to perform tasks outlined in the Health Plan/Emergency Action Plan. I release, indemnify, and hold harmless the District RN(s) and designated staff from any claims related to health interventions, provided they follow the healthcare provider's written instructions and/or agreed upon within this plan of care. I consent to communication and information sharing between the prescribing provider and District RN(s) as needed for managing my student's condition and administering medication. I understand that the information in this plan will be shared with school staff and EMS as necessary. EMS will be called in emergencies. I will notify District RN(s) of any changes in my child's health status, care, or medication. Parents/guardians and the student are responsible for providing all required supplies, medications, and equipment. This order expires at the end of the current school year or on an earlier date set by the provider: _____. I understand that this document is not valid, and no accommodations will be made, until it is signed by all required parties.			
Parent Signature:		Date:	
ER Contact Name:	Relationship:	Phone:	
This health care plan is to be distributed via PowerSchool or as needed by front office to all "need to know" staff.			
District Nurse Signature:		Date:	