Seizure action plan

Simplified individualized healthcare plan (IHP)

Emergency action plan (EAP)

Utah Department of Health and Human Services/

Utah State Board of Education

School year:

SMMO
☐ Yes ☐ No

Picture

Student information

Student name:	Date of birth:	Grade:	School:
Parent name:	Phone:		Email:
Physician name:	Phone:		Fax:
School nurse name:	School phone:		Fax:

History:

Section 504 plan

Students with epilepsy or seizure disorder may also need a separate Section 504 plan to provide accommodations necessary to access their education.

Seizure information

Seizure type/description	Length	Frequency

Seizure triggers or warning signs:

Student specific information:

Special considerations

Special considerations and precautions (regarding school activities, field trips, sports, etc):

Emergency seizure rescue medication (seizure medication management order required)

Person to give seizure rescue medication: ☐ School nurse ☐ Parent ☐ EMS
☐ Volunteer (specify): ☐ Other (specify):
Attach volunteer(s) training documentation

Location of seizure rescue medication (must be locked but accessible):

Implanted devices (provider order not required)

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". Wait one minute and repeat as needed for seizure activity.

Location of magnet (where in the school):

Person(s) trained on magnet use: ☐ School nurse ☐ Teacher ☐ Aide
☐ Volunteer (specify): ☐ Other (specify):
Attach volunteer(s) training documentation

Continued on next page

Student name:	Date of birth:	School year:

Seizure action plan – Mark all behaviors that apply to student

If you see this:	Do this:
☐ Sudden cry or squeal ☐ Loss of bowel or bladder control ☐ Staring ☐ Rhythmic eye movement ☐ Lip smacking ☐ Gurgling or grunting noises ☐ Falling down ☐ Rigidity or stiffness ☐ Thrashing or jerking ☐ Change in breathing ☐ Blue color to lips ☐ Froth from mouth ☐ Loss of consciousness ☐ Other (specify):	☐ Stay calm and track time seizure began ☐ Report symptoms and duration to parent ☐ Keep student safe ☐ Do not restrain ☐ Protect head ☐ Keep airway open and watch breathing ☐ Turn student on their side ☐ Do not put anything in their mouth ☐ Do not give fluids or food during or immediately after seizure ☐ Stay with student until fully conscious ☐ Make sure symptoms resolve before the student leaves classroom ☐ Swipe VNS magnet (if applicable) ☐ Other (specify):

Expected behavior after seizure	Emergency seizure protocol
▪ Tiredness ▪ Weakness ▪ Sleeping or difficult to arouse ▪ Somewhat confused ▪ Regular breathing ▪ Other (specify): **Follow-up** ● Notify school nurse ● Document observations	● Call EMS at ____ minutes for transport to:_____ hospital ● Call parent or emergency contact ● Administer emergency medications and/or oxygen as indicated on seizure medication management order ● Other (specify): **A seizure is generally considered an emergency when:** ▪ Convulsive (tonic-clonic) seizure lasts longer than 5 minutes ▪ Repeated seizures with or without regaining consciousness ▪ Breathing difficulties continue after seizure ▪ Seizure occurs in water

Signatures

As parent/guardian of the above named student, I give permission for my student'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 my responsibility to notify the school nurse of any change in my student's health status, care, or medication order. I am responsible for maintaining necessary supplies, medications, and equipment.

Parent name (print):	Signature:	Date:
Other emergency contact name:	Relationship:	Phone:

School nurse

Seizure emergency action plan (this form) distributed to "need to know" staff:

☐ Front office/admin staff ☐ Teacher(s) ☐ Transportation staff ☐ Other (specify):

School nurse signature:	Date:

Addendum: