Individualized Health Care PlanStudent Name: **School Year:**

Seizure Disorder Individualized Healthcare Plan

SECTION I			
Student:			**WT:** **HT:**
Grade:	**D.O.B**	**Any Known Allergies**	
School:			
District:		**Bus (check one) ☐YES ☐NO** **Bus #AM**	**Bus #PM**
School Nurse:		**Pager #**	**Cell #**
Medication taken at home: (please list)			

Contacts

Mother	**Home #**	**Work #**	**Pager/Cell #**
Father	**Home #**	**Work #**	**Pager/Cell #**
Guardian/Custodian	**Home #**	**Work #**	**Pager/Cell #**
Home Address		**City #**	**Zip**
Emergency Contact (Relationship)		**Home #**	**Work #**
Physician		**Phone #**	**Fax#**
Physician Address		**City**	**Zip**

Date	**Special Notes**

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SECTION II: EMERGENCY ACTION PLAN		
Does student experience an aura before seizures? □ No □ Yes If "Yes", describe:		
Behavior or activity student usually exhibits during seizures:		
IF YOU SEE THIS….		**DO THIS….**
Onset of Seizure Activity	Student HAS*VNS (Vagus Nerve Stimulator)	Swipe VNS with magnet per prescriber's order Then follow steps written below:
	Student DOES NOT have VNS (Vagus Nerve Stimulator)	Remain with student and provide verbal reassurance. Provide privacy. Do not restrain student. Note time at onset of seizure activity and time duration. Document activity noted, time of onset and duration on Seizure Log form. Contact parent.
Stiffening and jerking movements consistent with *Tonic-Clonic* or *Gran Mal* Seizure		Follow steps listed above, and…. Ease student to floor and place in side-lying position. Cushion student's head. Remove surrounding objects that could cause injury.
	Student DOES NOT have emergency medication ordered for school setting:	Call 9-1-1 if: • Seizure lasts longer than 5 minutes • Second seizure occurs before recovering from first seizure • Injury occurs during seizure
	Student HAS emergency medication ordered for school setting: *Medication: (Diastat &/or Versed to be administered by licensed nurse only)	Licensed School Nurse or trained Medication Assistant will administer medication per prescriber's order. Call 9-1-1 Note and document time medication was administered and any change in student's condition for report to EMS personnel

***ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION SIGNED BY THE PRESCRIBER**

School Nurse Use Only

***Medication and/or Magnet**	**Expiration Date**	**Self-Carry?**	**Location of Medication and/or Magnet**

Notes /Special Instruction_____

_____

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SECTION III:

Seizure Disorder, also known as **Epilepsy**, is a disorder of the central nervous system characterized by a tendency for recurrent seizures. The term "seizure" refers to sudden, uncontrolled episodes of abnormal behavior related to abnormal electrical discharges in the brain. A seizure is a symptom of the disorder just as fever is a symptom of infection. Seizure disorders are not contagious or a sign of mental illness. Only in rare cases do seizures require emergency intervention. Most seizures are over in a few minutes and do not require medical follow up.

Avoid circumstances that may lower seizure threshold (please list):

CLASSROOM:	PHYSICAL EDUCATION:
□ Observe student for evidence of seizure activity. • If seizure activity noted: ➢ Begin following steps listed in student's Emergency Action Plan ➢ Contact the School Nurse	□ Allow student to self-limit physical activity □ Observe student for evidence of seizure activity • If seizure activity is noted: ➢ Begin following steps listed in student's Emergency Action Plan ➢ Contact the School Nurse
Considerations for outdoor activities: □ Describe: □ None required □ Other: Additional Instructions/Notes:	Considerations for outdoor activities: □ Describe: □ None required □ Other: Additional Instructions/Notes:
FIELD TRIPS:	**BUS TRANSPORTATION:**
□ Student has Diastat order: □ Yes or □ No ➢ If "yes", student will be accompanied by Licensed Nurse or parent □ Student has other emergency medication □ Yes or □ No ➢ Student will be accompanied by trained Medication Assistant, Licensed Nurse or Parent □ Other:	If seizure activity noted, follow plan written here:
EMERGENCY DRILLS AND SCHOOL CRISIS EVENTS	**OTHER:**
□During Crisis Event Follow School Safety Plan. □ School Nurse will secure medications in accordance with school safety plan □ In event of building evacuation, School Nurse or Medication Assistant will evacuate with medications. □ In event of building evacuation, School Nurse Location is: □ Student requires assistance to evacuate building? □ No □ Yes ➢ If "yes", describe:	After School Care: Extracurricular Activity:

Individualized Health Care PlanStudent Name: **School Year:**

Written Notes/Addendum to Plan of Care

DATE		PARENT/ GUARDIAN INTIALS (if needed)

I understand and agree with this Individualized Healthcare Plan.

I give permission for my child to be transported to the hospital indicated on this form, in the event of an emergency.
I give permission for the release of my child's medical information, in the event of an emergency.

Signature of Parent or Guardian **Date**

Signature of School Nurse **Date**

Individualized Health Care Plan Student Name: **School Year:**

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name: _____ **School: _____**

Date of Birth: _____/_____/_____ Age: _____ Grade: _____ Teacher: _____

☐ **No known drug allergies---if drug allergies list: _____** Weight: _____pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ **Dosage: _____Route: _____**

Frequency/Time(s) to be given: _____ **Start Date: ___/____/____ Stop Date: ___/___/___**

Reason for taking medication: _____
Potential side effects/contraindications/adverse reactions: _____
Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes ☐ No ☐
Is self- medication permitted and recommended? Yes ☐ No ☐
If "yes" I hereby affirm this student has been instructed
On proper self-administration of the prescribe medication.
Do you recommend this medication be kept "on person" by student? Yes ☐ No ☐

Printed Name of Licensed Healthcare Provider: _____Phone: ( ) _____-_____ Fax: _____-_____

Signature of Licensed Healthcare Provider: _____ Date: _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____Date: ___/___/___ Phone: ( ) _____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ Date: ____/____/_____ Phone: ( ) _____-_____

Individualized Health Care PlanStudent Name: **School Year:**

Communication of the Individualized Health Care Plan

SECTION IV:

☐ Check this Box if Read Receipt is used to communicate Individualized Health Care Plan to staff.
* Nurse to attach Read Receipt document to this packet.

☐ Check this box if staff receives and signs below for Individualized Health Care Plan.

I have read and understand this student's Individualized Healthcare Plan, and have printed a copy to be maintained in my confidential folder/binder of instructions for substitute teachers.

I have been given the opportunity to ask questions.

I understand my role in addressing this students medical needs.

I am aware the school nurse is available to help clarify any future concerns.

Employee Name	Employee Signature	Position	Date