SEIZURE ACTION PLAN **Individualized Healthcare Plan (IHP)** **Emergency Action Plan (EAP)** **Utah Department of Health/ Utah State Board of Education**	School Year:	Picture
	SMMO ☐ Yes ☐ No	

STUDENT INFORMATION

Student:	DOB:	Grade:	School:
Parent:	Phone:		Email:
Physician:	Phone:		Fax:
School Nurse:	School Phone:		Fax:

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/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 (See SMMO)

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

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)

- Location of magnet (where in the school):
- Describe magnet use and location of implanted device:

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:	**DOB:**	**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 & track time ☐ Report symptoms and duration to parent ☐ Keep student safe ☐ Do not restrain ☐ Protect head ☐ Keep airway open/watch breathing ☐ Turn student on side ☐ Do not put anything in mouth ☐ Do not give fluids or food during or immediately after seizure ☐ Stay with student until fully conscious ☐ Ensure symptoms resolve before student leaves classroom ☐ Swipe VNS magnet (if applicable) ☐ Other (specify):
Expected Behavior after Seizure	**EMERGENCY SEIZURE PROTOCOL**
▪ Tiredness ▪ Weakness ▪ Sleeping, 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 SMMO ☐ 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 the responsibility of the parent/guardian to notify the School Nurse of any change in the student's health status, care or medication order. Parents/Guardian are responsible for maintaining necessary supplies, medications and equipment.

Parent Name (print):	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:

SCHOOL NURSE

Seizure Emergency Action Plan (this form) distributed to 'need to know' staff:
☐ Front office/admin ☐ Teacher(s) ☐ Transportation ☐ Other (specify):

School Nurse Signature:	Date:

Addendum: