McKinney Independent School District
School Health Services

Photo

Individualized Health Plan, Seizure

Reviewed & accepted as IHP for current school year only. RN signature/date _____

Student's Name: _____ Date of Birth: _____
Grade: _____ ID # _____ Homeroom Teacher: _____
How does your child get to and from school? ☐ Car ☐ Walk ☐ Bus #____ ☐ Other _____

Contact Information
Parent/Guardian: _____
Address: _____
Telephone: Home_____ Work_____ Cell_____
Telephone: Home_____ Work_____ Cell_____

Student's Doctor/Health Care provider:
Name: _____
Address: _____
Telephone: _____Fax:_____ Emergency Number:_____

Other Emergency Contacts
Name: _____
Relationship: _____
Telephone: Home _____ Work_____ Cell_____

Seizure signs and symptoms

Date of Seizure Diagnosis: _____

What type of seizure(s) does child have? _____How often do the seizures occur? _____
How long has it been since his/her last seizure? _____
Does he/she experience an aura before having a seizure? ☐ Yes ☐No
If yes, describe _____
Are there any warnings and/or behavior changes before the seizure occurs? ☐ Yes ☐No
If yes, describe _____
What might trigger a seizure in your child? _____
Have there been any recent changes in your child's seizure patterns? ☐ Yes ☐No
If yes, describe _____
How does your child react after a seizure is over? _____
How do other illnesses affect your child's seizure control? _____
Has your child ever been hospitalized for continuous seizures? ☐ Yes ☐No
If yes, explain _____

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SIGNS OF SEIZURES: PLEASE CHECK or CIRCLE BEHAVIORS THAT APPLY TO YOUR CHILD.			
SIMPLE SEIZURES	GENERALIZED SEIZURES	**DANGER SIGNS- CALL 911**	BEHAVIORS EXPECTED AFTER SEIZURE
☐ Lip smacking ☐ Behavioral outbursts ☐ Staring ☐ Twitching ☐ Other: _____	☐ Sudden cry or squeal ☐ Falling down ☐ Rigidity/Stiffness ☐ Thrashing/Jerking ☐ Loss of bowel/bladder control ☐ Shallow breathing ☐ Stops breathing ☐ Blue color to lips ☐ Froth from mouth ☐ Gurgling or grunting noises ☐ Loss of consciousness ☐ Other: _____	• Seizure lasts more than 5 minutes • Another seizure starts right after the 1st seizure • Loss of consciousness • Stops breathing • If seizure is the result of an injury or child is injured during seizure • If student is pregnant	• Tiredness • Weakness • Sleeping, difficult to arouse • Somewhat confused • Regular breathing • Other: _____ **ALL OF ABOVE CAN LAST A FEW MINUTES TO A FEW HOURS.**

Treatment of seizures:

Does student have a Vagus Nerve Stimulator (VNS)? _____ Where is magnet worn? _____

Describe use of the magnet: _____

Routine Medication(s) taken: ☐ Yes (explain) _____ ☐ No

Medication(s) needed at school	Amount to be given	Time to be given
1.		
2.		
3.		

IF GENERALIZED SEIZURE OCCURS:

1. If falling, assist student to floor, turn to side.
2. Loosen clothing at neck and waist; protect head from injury.
3. Clear away furniture and other objects from area.
4. Have another classroom adult direct students away from area.
5. TIME THE SEIZURE.
6. Allow seizure to run its course; DO NOT restrain or insert anything into student's mouth. Do not try to stop purposeless behavior.
7. During a general or grand mal seizure expect to see pale or bluish discoloration of the skin or lips. Expect to hear noisy breathing.

IF SMALLER SEIZURE OCCURS

(e.g., lip smacking, behavior outburst, staring, twitching of mouth or hands)

1. Assist student to comfortable, sitting position.
2. Time the seizure.
3. Stay with student, speak gently, and help student get back on task following seizure.

CALL 911 AND BEGIN CPR/FIRST AID PROCEDURES IF STUDENT EXHIBITS:

1. Absence of breathing or pulse.
2. Seizure of 10 minutes or greater duration.
3. Two or more consecutive (without a period of consciousness between) seizures which total 10 minutes or greater.
4. Continued unusually pale or bluish skin or lips or noisy breathing after the seizure has stopped.

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WHEN SEIZURE COMPLETED:

1. Reorient and assure student.
    a. Assist change into clean clothing if necessary.
    b. Allow student to sleep, as desired, after seizure.
    c. Allow student to eat, as desired, once fully alert and oriented.
2. A student recovering from a generalized seizure may manifest abnormal behavior such as incoherent speech, extreme restlessness, and confusion. This may last from five minutes to hours.
3. Inform parent immediately of seizure via telephone conversation if:
    a. Seizure is different from usual type or frequency or has not occurred at school in past month.
    b. Seizure meets criteria for 911 emergency call.
    c. Student has not returned to "normal self" after 30-60 minutes.
4. Record seizure on Seizure Activity Log.

Emergency Contacts:

The school nurse/Health services coordinator will make arrangements for the care of the student with seizures in the absence of the school nurse.

Position	Name	Cell Phone	Phone
School Nurse			
Alternate Nurse			
Staff Member			
Staff Member			

Notify parents/guardian or emergency contact in the following situations:

_____

_____

_____

Physician's Statement

I have reviewed the specialized plan of care and

_____ I approve it as written

_____ I approve it with the following modifications:

_____

_____

_____ I have attached an alternate plan of care

_____ _____ _____

Physician's Printed Name Physician's Signature Date

Phone_____ Fax number: _____

I understand that if at any time the supervising adult believes my child's life is in danger, Emergency Medical Services (911) will be activated, and I agree that my insurance carrier or I will assume the responsibility for all costs incurred as a result.
I request that this medication be given by a school employee. I understand that the School District, Board of Trustees, and District employees shall not be held responsible for damages or injuries resulting from administration of this medication.
I consent to the release of medical information contained on this form to school officials who have a legitimate educational interest in the information, according to MISD Board Policy and the Family Education and Privacy act. I give permission for the release of confidential information regarding my child's specific health problems to third parties, other than school officials, as required to facilitate medical care and/or treatment of my child. I authorize the nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

_____ _____

Student's Parent/Guardian Date

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Attach Photo

Health Condition Information Sheet
(For general staff use, copy and distribute as needed)

Student's Name _____ D.O.B. _____

Condition _____ Grade _____

Physician's Name _____ Phone # _____

Parent's Name(s) _____ Home Phone # _____

Street Address _____ Work Phone # _____

Employer _____ Cell/Mobile # _____

Emergency Contact #1 _____ Phone # _____

Emergency Contact #2 _____ Phone # _____

If signs or symptoms of the above condition are noted please take the following steps:

A) If this happens: _____

Then do this: _____

B) If this happens: _____

Then do this: _____

C) If this happens: _____

Then do this: _____

Please circle one of the following to indicate the level at which this student can perform this care.

Independently Needs Assistance/Supervision Cannot do for self

Additional Comments: _____

_____

_____

_____

The IHP has been reviewed and discussed by the school nurse &/or parent/guardian & have listed the above information as staff awareness and individualized student information to expedite the care of the student during times when a school nurse may not be readily available. **This form may also be completed by the campus RN when information from the physician or parent has not been received and a teacher/substitute teacher needs to be advised of a medical condition & steps to ensure safety during times when a school nurse may not be readily available.**

School RN's Printed Name: _____ Signature: _____ Date: _____

Optional Parent Printed Name: _____ Signature: _____ Date: _____

Optional MD Printed Name: _____ Signature: _____ Date: _____