**SEIZURE INDIVIDUAL HEALTH PLAN (IHP)**

**\*\*THIS FORM IS VALID FOR SCHOOL DAY, EXTENDED DAY, OVERNIGHT AND WEEKEND FIELD TRIPS**

|  |  |  |  |
| --- | --- | --- | --- |
| Student: | | | School Year: |
| DOB: | Grade: | School: | |

**----------------------THIS SECTION TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER--------------------------**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Seizure Type | | Length | Frequency | Description | |
|  | |  |  |  | |
| Seizure triggers/warning signs: | | | | | |
| Student’s response after a seizure: | | | | | |
| **Medications Required During Regular School Hours:** | | | | | |
| Emergency Med **✓** | Medication and Dose | | Time | Side Effects/Special Instructions | |
|  |  | |  |  | |
|  |  | |  |  | |
| **YES NO DOES STUDENT TAKE SEIZURE MEDICATION AT HOME, OUTSIDE OF REGULAR SCHOOL HOURS?**  **\*\*\***REQUIRED: CHECK YES OR NO | | | | | |
| YES NO DOES STUDENT HAVE A VAGUS NERVE STIMULATOR? If YES, describe magnet use: | | | | | |
| A seizure Emergency for THIS STUDENT is defined as: | | | Special Considerations/Precautions: | | |
| Basic Seizure First Aid:   * Stay calm and track time * Keep student safe * Do not restrain * Do not put anything in student’s mouth * Stay with student until fully conscious * Record seizure symptoms and length of time   For tonic-clonic seizure:   * Protect head * Keep airway open/monitor breathing * Turn student on side | | | A seizure is considered an Emergency when:   * Convulsive (tonic-clonic) seizure lasts >5 minutes * Student has repeated seizures without regaining consciousness * Student is injured * Student has diabetes * Student has a first time seizure * Student has breathing difficulties * Student has a seizure in water * Student has a seizure as defined as an emergency by HCP above   **\*Call 911 for all Seizure Emergencies**  **\*Parent/Guardian should be notified of all seizures** | | |
| **Licensed Health Care Provider Signature:** | | **Date:** | **Printed Name:** | | **Phone/Fax:** |

**---------------------------------THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN------------------------------------**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Mother/Guardian: | | | Father/Guardian: | | |
| Hm: | Wk: | Cell: | Hm: | Wk: | Cell: |
| Parent/Guardian Signature: | | Printed Name: | | Date: | |

**STAFF:** Form Rcv’d: \_\_\_\_\_\_\_\_\_\_\_\_ Med Loc.\_\_\_\_\_\_\_\_\_\_\_ € Entered in database € Exp. Date ✓ Nurse Rvw’d.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_