INDIVIDUALIZED HEALTHCARE PLAN FOR STUDENTS WITH SEIZURES
2023-2024 SCHOOL YEAR

To be completed by the Parent:

Student Name: _____ Grade: _____

Seizure triggers or warnings: _____

Student reaction **before** a seizure: _____

Student reaction **after** a seizure: _____

Any other illnesses that affect child's seizure control? _____

Has child ever been hospitalized for continuous seizures? _____

EMERGENCY CONTACTS	OTHER EMERGENCY CONTACTS
PARENT/GUARDIAN: _____	NAME: _____
PHONE: _____	PHONE: _____
DOCTOR: _____	NAME: _____
PHONE: _____	PHONE: _____

_____ (Student Name) has seizures as mentioned above and in the Individualized Healthcare Plan from the physician. I have provided to the school the physician's medication permission and instructions. I am requesting these instructions be carried out by the school. I have instructed my child about his/her seizures and how to communicate to an adult immediately if he/she is having a reaction. I will provide the medication with a proper pharmacy label and be aware of the expiration date to replace the medication. I hereby request the daily medication specified by the physician be given to the above named student, and it may be administered by medical or non-medical personnel. I understand that **emergency** seizure medication **will not** be given by any school personnel that is not a licensed medical professional. I understand **911** may be called if symptoms worsen.

Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Galveston-Houston, its servants, agents, any employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston-Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent Signature: _____ Date: _____

To be completed by School:

School Nurse/Health Coordinator: _____ Date: _____

Principal Signature: _____ Date: _____

Before & After Program Coordinator: _____ Date: _____
(If applicable)

Teacher notification provided by: _____ Date: _____

- School staff may be notified of the student's health condition and the treatment plan in case of an emergency.

INDIVIDUALIZED HEALTHCARE PLAN FOR STUDENT WITH SEIZURES
2023-2024 SCHOOL YEAR

To be completed by Physician:

Student Name: _____ Date of Birth: _____

Seizure triggers or warning signs: _____

Student reaction to seizure: _____

BASIC SEIZURE FIRST AID

- Stay calm and contact the school nurse
- Have other children move away from the child
- Track seizure start and stop time
- Ease the child to the floor and clear an area around the child so nothing can hurt the child
- Protect head and put something flat and soft under the child's head
- Turn child gently on their side to keep airway clear.
- Do not restrain or remove from wheelchair (unless emergency medication must be administered)
- Do not put anything in mouth
- Remain with student until fully conscious

EMERGENCY SEIZURES CALL 911

- Seizure lasting longer than 5 minutes
- Student does not regain consciousness
- Student has a first time seizure
- Student is injured or has diabetes
- Student has difficulty breathing
- Student has a seizure in water
- A second seizure begins shortly after the first one without consciousness between seizures

MEDICATION(S)/TREATMENT

Daily medication: _____

Dose: _____

Administer time: _____

Route: _____

EMERGENCY MEDICATION: CALL 911
Administered by School Nurse LVN or RN

Emergency medication: _____

Dose: _____

Administer Time: _____

Route: _____

Administer for seizures lasting more than _____ minutes.

Does Student have a **Vagus Nerve Stimulator (VNS)**?

☐ **NO** ☐ **YES**

Vagus Nerve Stimulation (VNS): **CALL 911 at 5 minutes**

- ☐ Swipe magnet at seizure onset
- ☐ Swipe for report of aura
- ☐ Repeat swipe_____times every _____ minutes if seizure persists

SEIZURE DESCRIPTION

Seizure type: _____

Length: _____

Frequency: _____

Seizure description: (check all that apply)

☐ Convulsions ☐ Involuntary rhythmic movements

☐ Staring ☐ Unconsciousness

☐ Stiffening ☐ Facial tics

Other information: _____

_____

After a seizure: _____

_____

Any special considerations or safety precautions:
(regarding school activities, sports, field trips, etc.)

_____

_____

Physician Signature Printed Name Phone# Date