


<b>SEIZURE School Health Plan (SHP) Emergency Action Plan (EAP)</b>	<b>PHOTO</b>	 <b>CACHE COUNTY</b> <small>SCHOOL DISTRICT</small> Nursing & Health Services Phone 435-752-3925 Fax 435-792-7796	<b>RN Approval</b>
		<b>SMMO:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>STUDENT INFORMATION</b>
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Student:	DOB:	School:	Grade:	Year:
Parent:	Phone:	Email:		
Physician:	Phone:	Email:		
School Nurse:	Phone:	Email:		

<b>HISTORY</b>
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<b>SECTION 504 PLAN</b>
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Students with epilepsy or seizure disorder may also need a separate Section 504 plan in place to provide accommodations necessary to access their education.

<b>SEIZURE INFORMATION</b>
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Seizure Type and Description	Length	Frequency

<b>SEIZURE TRIGGERS OR WARNING SIGNS</b>
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<b>STUDENT SPECIFIC INFORMATION</b>
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<b>SPECIAL CONSIDERATIONS AND PRECAUTIONS REGARDING SCHOOL ACITIVITIES, FIELD TRIPS, SPORTS, ETC.</b>
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<b>EMERGENCY SEIZURE RESCUE MEDICATION (See SMMO)</b>
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Person to give seizure rescue medication:  School Nurse  Parent  EMS  Volunteer(s)  Other: \_\_\_\_\_

<b>ATTACH volunteer(s) training documentation</b>
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<b>LOCATION OF SEIZURE RESCUE MEDICATION (MUST BE LOCKED but)</b>
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<b>IMPLANTED DEVICES</b>
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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  Volunteer(s)  Other: \_\_\_\_\_

<b>ATTACH volunteer(s) training documentation</b>
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<b>Student Name:</b>		<b>DOB:</b>
<b>SEIZURE ACTION PLAN – Check all behaviors that apply to student</b>		
<b>IF YOU SEE THIS</b>	<b>DO THIS (BASIC SEIZURE FIRST AID)</b>	
<input type="checkbox"/> Blue color to lips <input type="checkbox"/> Change in breathing <input type="checkbox"/> Falling down <input type="checkbox"/> Froth from mouth <input type="checkbox"/> Gurgling or grunting noises <input type="checkbox"/> Lip smacking <input type="checkbox"/> Loss of bowel/bladder control <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Rhythmic Eye movement <input type="checkbox"/> Rigidity/Stiffness <input type="checkbox"/> Staring <input type="checkbox"/> Sudden cry or squeal <input type="checkbox"/> Thrashing/Jerking <input type="checkbox"/> Other: _____	<input type="checkbox"/> Stay calm and track time <input type="checkbox"/> Report symptoms and duration to parent <input type="checkbox"/> Keep student safe <input type="checkbox"/> Do not restrain <input type="checkbox"/> Protect head <input type="checkbox"/> Keep airway open <input type="checkbox"/> Monitor breathing <input type="checkbox"/> Turn child on side <input type="checkbox"/> Do not give fluids or food during or immediately after seizure <input type="checkbox"/> Stay with student until fully conscious <input type="checkbox"/> Ensure symptoms resolve before student leaves classroom <input type="checkbox"/> Swipe VNS magnet (if applicable) <input type="checkbox"/> Other:	
<b>EMERGENCY SEIZURE PROTOCOL</b>		<b>EXPECTED BEHAVIORS AFTER SEIZURE</b>
<input type="checkbox"/> Call 911 (EMS) at _____ minutes <input type="checkbox"/> Call parent or emergency contact <input type="checkbox"/> Administer emergency medications as indicated on SMMO <input type="checkbox"/> Administer Oxygen if ordered <input type="checkbox"/> Other (specify):		<input type="checkbox"/> Tiredness <input type="checkbox"/> Weakness <input type="checkbox"/> Sleepy, difficult to arouse <input type="checkbox"/> Somewhat confused <input type="checkbox"/> Regular breathing <input type="checkbox"/> Other: _____ _____ _____ _____
<b>A Seizure is generally considered an Emergency when</b>		<b>FOLLOW-UP</b>
<input type="checkbox"/> Convulsive (tonic-clonic) seizure lasts longer than 5 minutes <input type="checkbox"/> Repeated seizures with or without regaining consciousness <input type="checkbox"/> Breathing difficulties continue after seizure <input type="checkbox"/> Student is injured, pregnant or has diabetes <input type="checkbox"/> Seizure occurs in water <input type="checkbox"/> Student has a first-time seizure		<input type="checkbox"/> Notify School Nurse <input type="checkbox"/> Document
<b>SIGNATURES</b>		
As parent/guardian of the above-named student, I give permission for my child’s healthcare provider to share information with the District 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 District Nurse of any change in the student’s health status, care, or medication order. If medication is ordered, I authorize school staff to administer medication described below to my child. If prescription is changed, a new SMMO must be completed before the school staff can administer the medication. Parent/Guardian is responsible for maintaining necessary supplies, medications and equipment. <b>This document is not valid and no specific accommodations will be made until signed by all parties.</b>		
<b>Parent Signature:</b>		<b>Date:</b>
<b>ER Contact Name:</b>	<b>Relationship:</b>	<b>Phone:</b>
This health care plan is to be distributed via PowerSchool or as needed by <b>front office</b> to all “need to know” staff.		
<b>District Nurse Signature:</b>		<b>Date:</b>