Individualized Healthcare Plan: Seizures (page 1)

PARENT COMPLETES

Student Name: _____ DOB: _____ Class/Grade: _____

Sports or after school activities: _____

Age at first seizure: _____ Date of last seizure: _____ Has Diastat ever been administered to your child? Yes / No

Seizure triggers (if known): _____ Meds rx'd to manage seizures: _____

Does your child experience any aura prior to a seizure episode? Y / N If yes, please describe: _____

TO BE COMPLETED BY SCHOOL NURSE

ASSESSMENT	NURSING DX	STUDENT GOALS	INTERVENTIONS	STUDENT OUTCOME
Prescribed med(s) _____ _____ _____ Other: _____ _____ _____ _____ _____ _____	❑ Potential for injury r/t uncontrolled movements of seizure activity ❑ Potential for aspiration r/t seizure activity ❑ Risk for injury from falling during seizure activity ❑ Potential self-esteem disturbance r/t seizure disorder ❑ Risk for fatigue r/t: ❑Type of seizure activity ❑Frequency of seizure activity ❑Severity of seizure activity	❑ Student will not experience injury during seizure ❑ Student will not aspirate during seizure ❑ Student will demonstrate safety measures (when aura presents prior to seizure) in order to prevent injury ❑ Student will verbalize positive feelings about self. ❑ Student will (as developmentally appropriate) assist in the decision-making process regarding health management issues at school.	❑ Reduce or remove factors that may cause or contribute to injury during seizure. ❑ Educate all school staff about seizures. ❑ Provide student-specific info to select personnel for student: ❑Type of seizure, treatment regimen, including medication side effects ❑Precautions, safety issues ❑First aid care for immediate and recovery care ❑Emergency Plan of care and follow up ❑Evacuation Plan ❑ Obtain current medical orders. ❑ Document seizure activity during school. ❑ Establish communication with parents and health care provider. ❑ Provide for first aid and emergency care during seizure. ❑ Position child on side during seizure to prevent aspiration. ❑ Establish trusting relationship with student. ❑ Enhance student's sense of self-esteem. ❑ Provide emotional support for student,	❑ Student will not sustain injury during seizure while at school. ❑ Student will (if developmentally able) describe symptoms that accompany aura. ❑ Student will wear a medical alert bracelet if parents have supplied it. ❑ Student will ask teacher for clarification of instructions or directions that were missed on account of seizure activity (if student aware seizure has occurred). ❑ Student will follow a schedule that allows for regular meals,

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			classmates and staff.	sleep and rest time. ❑ Student will develop positive coping mechanisms.

Additional Notes: _____

_____

_____

_____

Parent/Guardian Statement: I have read this plan and agree to its implementation.

Parent/Guardian Signature: _____ Date: _____

Student Signature (if age-appropriate): _____ Date: _____

Nurse Signature: _____ Date: _____

Annual IHP Review (for subsequent years):

Parent/Guardian Signature:	Date:	*Parent/Guardian Signature*:	Date:
Student Signature (if age-appropriate):	Date:	*Student Signature (if age-appropriate)*:	Date:
Nurse Signature:	Date:	*Nurse Signature*:	Date:
Parent/Guardian Signature:	Date:	*Parent/Guardian Signature*:	Date:
Student Signature (if age-appropriate):	Date:	*Student Signature (if age-appropriate)*:	Date:
Nurse Signature:	Date:	*Nurse Signature*:	Date: