**SUMTER COUNTY SCHOOLS**
**INDIVIDUALIZED HEALTH CARE PLAN SEIZURE**

Date Initiated: _____
Date Reviewed: _____
Date Reviewed: _____
Date Discontinued: _____

Student Name: _____ DOB: _____ School: _____ Grade: _____
Parent/Guardian: _____ Contact #'s: Home _____ Cell _____ Work _____
_____ Home _____ Cell _____ Work _____
Other Emergency Contacts: _____ Contact #: _____
_____ Contact #: _____
Physician: _____ Phone #: _____ Fax #: _____

Medical Diagnosis: _____ Allergies: _____ Medications at Home: _____ at School: _____

| **ESE:** Yes No | **IEP:** Yes No | **504:** Yes No |
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Parent Signature: _____ Date _____ Nurse Signature _____ Date _____
Preferred Hospital: _____

| Nursing Diagnosis | Goals | Interventions | Outcomes/By Whom/When |
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| 1.___ Potential for seizures at school | 1.___ Student will maintain optimum health, safety and wellbeing during the school day | 1. Kind of seizure: _____<br>Usual frequency of seizures: _____<br>Date of last seizure: _____<br>**Events which may precipitate a seizure:**<br>_____<br>_____<br>_____<br><br>2.__ Student will be monitored for signs of seizure activity including:<br>• Blank for fixed eyes<br>• Loss of awareness<br>• Sudden dropping/falling to the floor<br>•Aimless movements<br>• Whole body tremors, loss of consciousness | School personnel-ongoing |

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| | | • Other: _____<br>• Other: _____<br><br>3.__ If seizure activity is noted, the seizure management procedure will be followed to maintain open airway and prevent injury.<br>• Do not restrict movement<br>• Do not place anything in student's mouth<br>• Protect from injury<br>• clear area of hazards<br>• protect head<br>• prepare to protect form sudden fall to the floor<br>• roll on side<br>• other: _____<br>• other: _____<br><br>**Other nursing intervention specific to this student during seizure:**<br>_____<br>_____<br><br>4.__ Student's privacy and dignity will be maintained during a seizure at school.<br><br>5.__ All seizure activity should be recorded on individual student log.<br><br>6.__ Student will be allowed to rest after a seizure if necessary and parent will be notified of seizure.<br>___ Rest in classroom<br>___ Rest in school clinic, then return to class<br>___ Rest in clinic<br>___ Go home<br><br>7.___ Parent/Guardian will be called if seizure is unusual or lasts more than **_____ minutes.** | School personnel - ongoing<br><br>All school staff and personnel<br><br>School nurse, school health staff, trained school personnel - ongoing<br><br>School nurse, school health |

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| | | 8.___ Diastat will be administered per physician orders.<br>___ at onset of seizure<br>___ at **_____ minutes** after onset of seizure<br><br>9.___ **CALL 911 (EMS)**<br>**___ at onset of seizure**<br>**___ at _____ minutes after onset of seizure**<br>**___ at _____ minutes after Diastat is given, if seizures are continuous (status epilepticus).** | staff, trained school personnel – ongoing<br><br>School nurse, other school personnel, as necessary |
| 2.___ Potential for accidents or injury related to seizures | 1.___ Student will maintain safety while increasing independence in self health management. | 1.___ Student will participate fully in the educational program.<br><br>2.___ Parents will be informed of potential risks for injury on the school campus.<br><br>3.___ The following adaptations or precautions will be needed during times of minimal adult supervision; such as: when student is on playground, walking across campus, in the cafeteria, on a field trip, etc.<br>_____<br>_____<br>_____<br>_____ | Student/School Nurse – ongoing<br><br>School nurse, school personnel, teachers - ongoing<br><br>Instructional personnel-as needed |
| 3.___ Potential need for medication management for seizures | 1.__ Student will cooperate with medical treatment plan during the school day. | 1.___ Student will come to the school clinic for supervised administration of the following medication (s) according to written physician's orders:<br>**Medication(s) Dose Time**<br>**_____**<br>**_____**<br><br>2.___ Student will have medication administered in classroom by trained staff (s) according to written physician's orders:<br>**Medication(s) Dose Time**<br>**_____**<br>**_____** | Student/School nurse<br>As ordered by physician<br><br>Teachers, trained school personnel |

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| | | **Document name of trained staff**<br>__ Personnel _____ Date: _____<br>__ Personnel _____ _____<br>__ Personnel _____ _____<br>__ Aide _____ _____<br>__ Aide _____ _____<br>__ Aide _____ _____<br>__ Bus Driver _____ _____<br>__ Other _____ _____<br><br>3.___ This plan also covers field trips/after school sponsored activities. These events will be discussed with the parent/guardian in advance so student's medical needs can be accommodated. Trained school staff will accompany student on off campus trips, if needed. | Teachers/classroom instructors, trained school personnel |
| 4.___ Knowledge deficit and loss of self-esteem related to seizure disorder | 1.___ Student will increase/maintain self-esteem and effective seizure management at school. | 1.___ The student will be given information and health counseling related to seizure disorder and management appropriate to level of understanding.<br><br>2.___ The student's medical condition will be discussed with him/her as needed to assure that appropriate level of knowledge is being maintained.<br><br>3.___ The classroom teacher will be provided information, support, and consultation regarding management of this student's health needs.<br><br>4.___ A copy of the EAP will be given to teachers and should be placed in substitute teacher folder, when not in use. | School nurse-ongoing or as requested.<br><br>Teacher |
| 5.___ Potential for change in medical status | 1.___ The student will, age appropriate, collaborate with the facilitation of his/her optimum health and safety necessary for learning. | 1.___ Parent/guardian will provide the school nurse with a copy of the current physician orders at the beginning of each school year and when changes occur in medical status.<br><br>2.___ The school nurse will call the student's doctor to obtain current medical information verbally when this is necessary to manage the student's condition at school.<br><br>**Physician or Healthcare Provider:**<br>**Name: _____**<br>**Phone number: _____** | Parent or guardian<br><br>School nurse– as needed |

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| 6.___ An Individual Health Care Plan (IHCP) will be reviewed annually with parent/guardian and with appropriate school personnel. This plan may be revised/updated as needed to ensure the most current treatment for the student. The school nurse, in collaboration with the parent/guardian, will supervise, train and delegate to UAP any portion of this plan as appropriate. | 1.___ The IHP will be updated and revised annually to meet the health needs of the student. | 1.__ Review/updated Date: _____<br>RN Initials: _____<br>Parent/guardian Initials: _____<br><br>Review/updated Date: _____<br>RN Initials: _____<br>Parent/guardian Initials: _____<br><br>Review/updated Date: _____<br>RN Initials: _____<br>Parent/guardian Initials: _____ | School nurse, school health staff, parent/guardian, appropriate school personnel |

☐ **Obtained via telephone interview with parent School Year _____**

☐ **Obtained via telephone interview with parent School Year _____**

☐ **Obtained via telephone interview with parent School Year _____**

*** As parent/guardian by signing this Health Care Plan, I authorize designated Sumter County School personnel, Sumter County Health Department School personnel, and any other contracted health care agencies to provide emergency care for my child and/or to share or exchange medical information as necessary to support the education and continuity of care of my child. I also give permission for the Sumter County Schools to share this information with faculty/staff who are directly involved in my child's education.**

***Note: 1. Significant changes to the health plan of care requires a new Individual Health Care Plan be completed.**
**2. At the beginning of the 4th school year based on the initial date of this plan a new IHCP will be written.**