INDIVIDUALIZED SEIZURE HEALTH PLAN

SCHOOL YEAR_____ CAMPUS_____

NAME: DOB: Regular IHCP ❑ 504 IHCP ❑

TYPE OF SEIZURES:

Behavior BEFORE seizure:

Behavior DURING seizure (include duration and frequency):

Behavior AFTER seizure

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

- ☐ This condition is **NOT** life threatening. No intervention is needed at this time.
- ☐ This condition is **NOT** life threatening. However, accommodations are needed (see below).
- ☐ This **IS** a life threatening condition. An action plan is needed (see below).

ACTION PLAN: **NEVER SEND STUDENT OUT OF CLASSROOM WITHOUT AN ESCORT**

BASIC MANAGEMENT

- Stay calm and do not leave student unattended.
- Note time of onset of seizure.
- Protect head and or body from injury by removing objects around.
- Help to the ground if loss of consciousness occurs and turn student *on side.*
- DO NOT restrain student.
- Send for help.
- Have office staff contact parent.
- Allow student to rest after seizure is over.

CALL 911 IF:

- Student turns blue and/or stops breathing (Begin CPR if not breathing).
- Seizure lasts longer than___ minutes.
- The student has a series of seizures.
- The student requests to be transported via ambulance.

OTHER INSTRUCTIONS FROM HCP (classroom, school bus, field trips, disaster, etc.)

Other health concerns:

Medications:	**Dose/Time:**

Parent Signature: **Date**:

M.D. Signature (or Med. Authorization form): **Date**:

CONTACT INFORMATION

Parent/Guardian:	**Home phone:**
1._____	Work:_____ Cell:_____
2._____	Work:_____ Cell:_____

P C Physician Name/ phone #: **Specialty Physician Name/ phone #:**	**Teacher**:
Emergency contact:	**Phone:**

Copies: □ Parent □ Teacher _____ □ PE □ Library □ Music □ Transportation □ Nurse