



# Individualized Health Plan (IHP) Seizure Action Plan



School Name:		Date:	
Student's Name:		Date of Birth:	
Parent/Guardian:	Phone:	Cell:	
Other Emergency Contact:	Phone:	Cell:	
Treating Physician:		Phone:	
Significant Medical History:			
<b>Seizure Information</b>			
Seizure Type	Length	Frequency	Description
Seizure triggers or warning signs:			
Student's response after a seizure:			
<b>Basic First Aid Care &amp; Comfort</b>		<b>Basic Seizure First Aid</b>	
		<ul style="list-style-type: none"> <li>Stay calm &amp; track time</li> <li>Keep child safe</li> <li>Do not restrain</li> <li>Do not put anything in mouth</li> <li>Stay with child until fully conscious</li> </ul>	
		<p><b>For tonic-clonic seizure:</b></p> <ul style="list-style-type: none"> <li>Protect head</li> <li>Keep airway open/watch breathing</li> <li>Turn child on side</li> </ul>	
<b>Emergency Response</b>		<b>A seizure is generally considered an emergency when;</b>	
A "seizure emergency" for this student is defined as:	<p><b>Seizure Emergency Protocol</b> (check all that apply and clarify below)</p> <p>Contact school nurse at: _____</p> <p>Call 911 for transport to: _____</p> <p>Notify parent of emergency contact: _____</p> <p>Administer emergency medications as indicated below</p> <p>Notify doctor</p> <p>Other: _____</p>		<ul style="list-style-type: none"> <li>Convulsive (tonic-clonic) seizure lasts longer than 5 minutes</li> <li>Student has repeated seizures without regaining consciousness</li> <li>Student is injured or has diabetes</li> <li>Student has a first time seizure</li> <li>Student has breathing difficulties</li> <li>Student has a seizure in water</li> <li>Student is pregnant</li> </ul>
<b>Treatment Protocol During School Hours (include daily and emergency medications)</b>			
Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions	
Emergency/Medication:	Dose:	Give After:	min(s).
Route:			
Special Instructions:			
Special Considerations & Safety Precautions: (regarding school activities, sports, trips etc.)			
Physician Signature:		Parent/ Guardian Signature:	
Date:		Date:	