SEIZURE DISORDER

Student Name: ______________________________ DOB: _________________ School: ____________________________
School Nurse: ________________________________ Date of IHP: ___________________
Physician Name: _____________________________ Ph. #: _____________ Parent signature: ______________________

Nursing Diagnosis/Concern	Educational Goal	Plan of Action	By Whom/When
1. Potential for seizures at school	1. Student will maintain optimum health, safety and well-being during the school day	1. Kind of seizure: ______________________ Usual frequency of seizures: ________________ Date of last seizure: _______________________ Events which may precipitate a seizure: □ ________________________ □ ________________________ □ ________________________ □ Student will be monitored for signs of seizure activity including: □ ______________________ □ ______________________ □ ______________________ □ ______________________ If seizure activity is noted, the seizure management procedure will be followed to maintain open airway and prevent injury. Other nursing intervention specific to this student during seizure: □ ______________________ □ ______________________	School personnel-ongoing basis

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		Student's privacy and dignity will be maintained during a seizure at school. All seizure activity will be recorded on individual student log. Student will be allowed to rest after a seizure if necessary. ☐ Rest in classroom ☐ Rest in nurse's office ☐ Parent will be called and student will go home. ☐ ____________________________________ Parent/guardian will be called if seizure is unusual or lasts more than _____ minutes. CALL 911 EMERGENCY MEDICAL SERVICES if seizures are continuous (status epilepticus) or if: ____	All school personnel-ongoing basis. School Nurse's office-ongoing
Potential for accidents or injury related to seizures	Student will maintain safety while increasing independence in self health management.	Student will participate fully in the educational program. Parents will be informed of potential risks for injury on this school campus. 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. ____________________________________ ____________________________________ ____________________________________ ____________________________________	Student/School Nurse Instructional personnel-as needed

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Potential need for medication management for seizures	Student will cooperate with medical treatment plan during the school day.	Student will come to the Nurse's office for supervised administration of the following medication (s) according to written physician's orders: **Medication(s)** **Dose** **Time** **The LLS medication policy will be followed at all times.**	Student/School nurse-as ordered by physician
Knowledge deficit and loss of self-esteem related to seizure disorder	Student will increase/ maintain self-esteem and effective seizure management at school.	The student will be given information and health counseling related to seizure disorder and management appropriate to level of understanding. ▫ Classroom presentations will be given on seizure disorders as appropriate and when requested. ▫ The student's medical condition will be discussed with him/her as needed to assure that appropriate level of knowledge is being maintained. ▫ The classroom teacher will be provided information, support, consultation regarding management of this student's health needs.	School nurse-ongoing or as requested.

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Potential for change in medical status	The student will, age appropriate, collaborate with the facilitation of his/her optimum health and safety necessary for learning.	Parent/guardian will provide the school nurse with a copy of the current medical report or the physician's annual statement OR when changes occur in medical status. The school nurse will call the student's doctor to obtain current medical information verbally when this is necessary to manage the students condition at school. **Physician or PCP Name: ________________** **Phone number: _____________**	Parent or guardian School nurse– as needed
This Health Management plan will be reviewed annually by the school nurse, or, as often as needed, with the parent/guardian and appropriate instructional assistants. It will be revised prn. The school nurse will, in collaboration with the parent/ guardian, train or arrange training, and supervise all non-medically licensed school personnel who are assigned responsibility for implementing any part of this health plan.	The IHP will be updated and revised annually to meet the needs of the student.	<table><tr><th>Review Date:</th><th>RN Initials:</th><th>Parent Initials:</th></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td></tr></table>	School nurse-annually or as needed.