INDIVIDUALIZED HEALTHCARE PLAN FOR STUDENTS WITH SEIZURES 2023-2024 SCHOOL YEAR

| To be completed by the Parent: | |
|--|---|
| tudent Name:Grade: | |
| Seizure triggers or warnings: | |
| Student reaction before a seizure: | |
| Student reaction after a seizure: | |
| Any other illnesses that affect child's seizure control? _ | |
| Has child ever been hospitalized for continuous seizure | es? |
| EMERGENCY CONTACTS | OTHER EMERGENCY CONTACTS |
| PARENT/GUARDIAN: | NAME: |
| PHONE: | PHONE: |
| DOCTOR: | NAME: |
| PHONE: | PHONE: |
| agreeing to allow the medication to be given to the studen Archdiocese of Galveston-Houston, its servants, agents, any principal, and the individuals giving the medication, of and to or in any way connected with the giving of the medication consideration, I, on behalf of myself and the other parent of | If my agreements contained herein. In consideration for the school t as requested herein, I agree to indemnify and hold harmless the remployees, including, but not limited to the parish, the school, the from any and all claims, demands, or causes of action arising out of or failing to give the medication to the student. Further, for said the student, hereby release and waive any and all claims, demands, buston, its agents, servants, or employees, including, but not limited wing or failing to give the medication. |
| Parent Signature: | Date: |
| To be completed by School: | |
| School Nurse/Health Coordinator: | Date: |
| Principal Signature: | Date: |
| Before & After Program Coordinator: | Date: |
| Γeacher notification provided by: | Date: |

School staff may be notified of the student's health condition and the treatment plan in case of an emergency.

INDIVIDUALIZED HEALTHCARE PLAN FOR STUDENT WITH SEIZURES

| 2023-2024 SCHOOL YEAR To be completed by Physician: | |
|---|---|
| • | Date of Birth: |
| Seizure triggers or warning signs: | |
| Student reaction to seizure: | |
| BASIC SEIZURE FIRST AID Stay calm and contact the school nurse Have other children move away from the child Track seizure start and stop time Ease the child to the floor and clear an area around the child so nothing can hurt the child Protect head and put something flat and soft under the child's head Turn child gently on their side to keep airway clear. Do not restrain or remove from wheelchair (unless emergency medication must be administered) Do not put anything in mouth Remain with student until fully conscious | EMERGENCY SEIZURES CALL 911 Seizure lasting longer than 5 minutes Student does not regain consciousness Student has a first time seizure Student is injured or has diabetes Student has difficulty breathing Student has a seizure in water A second seizure begins shortly after the first one without consciousness between seizures |
| MEDICATION(S)/TREATMENT Daily medication: Dose: | SEIZURE DESCRIPTION Seizure type: Length: |
| Administer time: Route: EMERGENCY MEDICATION: CALL 911 Administered by School Nurse LVN or RN | Frequency: Seizure description: (check all that apply) □ Convulsions □ Involuntary rhythmic movements |
| Emergency medication: Dose: Administer Time: | ☐ Staring ☐ Unconsciousness ☐ Stiffening ☐ Facial tics Other information: |
| Route: Administer for seizures lasting more than minutes. Does Student have a Vagus Nerve Stimulator (VNS)? | After a seizure: |
| □ NO □ YES Vagus Nerve Stimulation (VNS): CALL 911 at 5 minutes □ Swipe magnet at seizure onset □ Swipe for report of aura □ Repeat swipetimes every minutes if seizure persists | Any special considerations or safety precautions: (regarding school activities, sports, field trips, etc.) |

Physician Signature Printed Name Phone# Date