SUMNER COUNTY SCHOOLS
SEIZURE IHP/SAFETY PLAN-PRESCRIPTION MEDICATION ORDERS

This portion is to be completed by a PARENT/GUARDIAN

Child Information

Name of Child:_____ Date of Birth_____

Child's Age_____ Grade_____ Homeroom Teacher_____

Emergency Information

Emergency Contact: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Parent/Guardian: _____ Phone 1: _____ Phone 2: _____

Neurologist: _____ Phone: _____

Primary Physician: _____ Phone: _____

Triggers that may bring on a seizure:_____

Date of last seizure: _____

Signs and symptoms: (Please circle the symptom(s) that occur in your child.)

1. Aura (symptoms before seizure_____)
2. Generalized convulsions involving entire body
3. Pallor or skin discoloration
4. Labored (noisy) breathing
5. Dilation of pupils
6. Loss of consciousness (may fall to ground)
7. Involuntary loss of urine or feces
8. Staring / blank gaze / day dreaming
9. Other_____

Is your child aware of impending seizure activity? YES NO

PARENT/GUARDIAN: It is critical for school personnel to know about same day use of Diazepam, or other emergency anti-seizure medications prior to school. Diazepam rectal gel (Diastat) is not to be used more than 5 times per month and/or more than once in 5 days.

List ALL current medications:

Medication	Dosage/Strength	Purpose	Day/Schedule	Time of Day

My child has the following other chronic illnesses/disabilities: _____

Allergies:_____

Child's Limitation or Special Considerations:_____

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the health care provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Sumner County School System, the undersigned parent or guardian hereby understands and agrees that the Sumner County School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication (T.C.A. § 49-5-415). By signing, parent indicates agreement with the plan of action as described by health care provider.

- ☐ Student information was requested from the parent with no response. This IHP was developed by the school nurse without input from the parents.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Nurse Use Only: DIASTAT LOCATED _____. Only parent, nurse or trained personnel can administer Diastat. If given call 911, document on *Emergency Medication MAR*. If no trained personnel available, call 911.

4/2017

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This portion is to be completed by the PHYSICIAN

Child's Name: _____ DOB: _____

DURING SEIZURE ACTIVITY:

1. STAY WITH THE STUDENT & NOTIFY THE SCHOOL NURSE and/or SET TEAM.
2. Note time at onset of seizure, observe pattern of the seizure and document on the seizure log.
3. If generalized jerking occurs, assist student to the floor (if student is in a wheelchair lock the wheels and allow the student to remain in the chair).
    a. Gently support head, roll student to side position and monitor breathing and pulse.
    b. **DO NOT** restrain student or place anything in the student's mouth.
    c. Protect student by moving items away that may cause injury.
    d. Loosen clothing at neck and waist; remove eyeglasses (if applicable).
4. Have another adult remove other students from the area.
5. **CALL 911 & PARENT IF CHILD EXHIBITS:**
    a. Absence of breathing and/or pulse. (Start CPR for absence of breathing and pulse.)
    b. Seizure of 5 minutes or greater duration.
    c. Two or more consecutive (without a period of consciousness between) seizures which total 5 minutes or greater.
    d. Continued unusually pale or bluish skin/lips or noisy breathing after the seizure has stopped.
    e. If Diastat is ordered and given.
    f. If Diastat is ordered and no trained staff member or school nurse is available at the onset of the seizure.

Emergency & Other Medication(s) to be Administered at School (Including VNS magnet, if applicable)

Name & Purpose of Medication	Strength & Dose to be Given	When to Administer at School/Frequency	Possible Side Effects of Medication

This child has the following chronic illnesses/disabilities: _____

AFTER SEIZURE ACTIVITY:

1. Continue to monitor until the student is alert and oriented.
2. Provide for personal hygiene and privacy, as appropriate. If the student is tired after a seizure allow to rest in a supervised area, as needed.
3. A child recovering from a generalized seizure may manifest abnormal behavior, such as incoherent speech, extreme restlessness, and confusion. This may last from five minutes to several hours.
4. **Notify parent if seizure is different from usual type, 911 is called or child has not reoriented after 30-60 minutes**.

Physician's Signature: _____ Date: _____

Physician's Name (Print): _____ Phone: _____

Nurse Use Only: DIASTAT LOCATED _____. Only parent, nurse or trained personnel can administer Diastat. If given call 911, document on *Emergency Medication MAR*. If no trained personnel available, call 911.

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