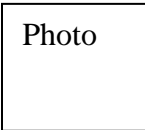


McKinney Independent School District
School Health Services
Individualized Health Plan, Seizure



Reviewed & accepted as IHP for current school year only. RN signature/date _____

Student's Name: _____ Date of Birth: _____
 Grade: _____ Student ID#: _____ Homeroom Teacher: _____
 How does your child get to/from school? Car _____ Walk _____ Bus _____ Other _____

Parent(s)/Guardian(s): _____
 Number(s): _____
 Other Emergency Contact: _____ Relationship: _____
 Home: _____ Cell: _____ Work: _____

Date of Seizure Diagnosis: _____ When was last seizure? _____

Seizure Type/Nickname	What Happens	How Long it Lasts	How Often

Triggers: _____
 List any recent changes in your child's seizure patterns: _____
 How does your child react after seizure is over? _____
 How do other illnesses affect your child's seizure control? _____
 Has child ever been hospitalized for continuous seizures? Yes/No If YES, explain: _____

Signs of Seizures: Please check all that apply

Simple Seizures: Lip Smacking Behavioral outbursts Staring Twisting Other: _____
Generalized Seizures: Sudden cry or squeal Falling down Rigidity/stiffness Thrashing/jerking Shallow breathing
 Loss of bowel/bladder control Blue color to lips Froth from mouth Gurgling or grunting noises Loss of consciousness Other: _____

Daily Medication	Total Daily Amount	Amount of Tab/Liquid	Time/Amount of Each Dose

Other Seizure Treatments

Device Type: _____ Model: _____ Serial#: _____ Date Implanted: _____
 Dietary Therapy: _____ Date Began: _____
 Other Therapy: _____
 Special Instructions _____

PRN Medication/Treatment at School	Amount to Give	When to Give	How to Give

Seizure First Aid

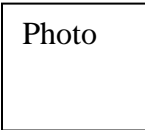
- Keep calm, provide reassurance, remove bystanders
- If falling, assist student to floor and turn on side
- Keep airway clear, nothing in mouth
- Loosen clothing at neck and waist
- Protect head from injury
- Keep safe, remove objects, do not restrain
- Time, observe, record what happens
- Stay with person until recovered from seizure

Other care needed: _____

Call 911

- Generalized seizure lasts more than 5 minutes
- Two or more seizures without recovering between seizures
- PRN Medication/treatments do not work
- Injury occurs or is suspected, or seizure occurs in water
- Breathing, heart rate, or behavior doesn't return to normal
- Unexplained fever or pain, hours or few days after seizure
- Other: _____

McKinney Independent School District
School Health Services
Individualized Health Plan, Seizure



Student's Name: _____

When Seizures Require Additional Help

Type of Emergency	Description	What to Do

When Seizure is Complete:

- 1) Reorient and assure student
- 2) Assist student into clean clothing if needed
- 3) Allow student to sleep, as desired
- 4) Allow student to eat, as desired, after fully alert and oriented
- 5) A student recovering from a generalized seizure may manifest incoherent speech, extreme restlessness, and confusion. This may last for several hours.
- 6) Inform parent immediately if:
 - o Seizure is different from usual type or frequency or has not occurred at school in past month
 - o Seizure meets criteria for 911 emergency call
 - o Student has not returned to "normal self" after 60 minutes
 - o Other: _____

Physician's Printed Name _____ **Physician's Signature** _____ **Date** _____
Phone number _____ **Fax number** _____

Position	Name	Cell Phone	Work Phone
School Nurse			
Alternate Nurse			
Staff Member			
Staff Member			

504 Accommodations

I understand my child may be eligible for 504 accommodations. Please initial one of the following.
 _____ I am interested in learning more about 504 accommodations.
 _____ My student is already serviced by 504 accommodations. The last 504 meeting date was _____.
 _____ I am not interested in pursuing 504 accommodations at this time.

I understand that if at any time the supervising adult believes my child's life is in danger, Emergency Medical Services (911) will be activated and I agree that my insurance carrier or I will assume the responsibility for all costs incurred as a result. I request this medication be given by a school employee. I understand that the School District, Board of Trustees, and District employees shall not be held responsible for damages or injuries resulting from administration of this medication.
I consent to the release of medical information contained on this form to school officials who have a legitimate educational interest in the information, according to MISD Board Policy and the Family Education and Privacy act. I give permission for the release of confidential information regarding my child's specific health problems to third parties, other than school officials, as required to facilitate medical care and/or treatment of my child. I authorize the nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas)

Parent's Printed Name: _____ Signature: _____ Date: _____

The following medication was destroyed due to failure to pick up the medication prior to the last day of school, medication was discontinued or medication was picked up by parent:

Medication(s) name & amount disposed _____ Time _____ Date _____

RN Signature: _____ Witness Signature: _____

OR

Medication(s) name & amount picked up _____
 Parent signature and date _____

**McKinney Independent School District
School Health Services**

Attach
Photo

Health Condition Information Sheet
(For general staff use, copy and distribute as needed)

Student's Name _____ D.O.B. _____

Condition _____ Grade _____

Physician's Name _____ Phone # _____

Parent's Name(s) _____ Home Phone # _____

Street Address _____ Work Phone # _____

Employer _____ Cell/Mobile # _____

Emergency Contact #1 _____ Phone # _____

Emergency Contact #2 _____ Phone # _____

If signs or symptoms of the above condition are noted please take the following steps:

A) If this happens: _____

Then do this: _____

B) If this happens: _____

Then do this: _____

C) If this happens: _____

Then do this: _____

Please circle one of the following to indicate the level at which this student can perform this care.

Independently

Needs Assistance/Supervision

Cannot do for self

Additional Comments: _____

The IHP has been reviewed and discussed by the school nurse &/or parent/guardian & have listed the above information as staff awareness and individualized student information to expedite the care of the student during times when a school nurse may not be readily available. **This form may also be completed by the campus RN when information from the physician or parent has not been received and a teacher/substitute teacher needs to be advised of a medical condition & steps to ensure safety during times when a school nurse may not be readily available.**

School RN's Printed Name: _____ Signature: _____ Date: _____

Optional Parent Printed Name: _____ Signature: _____ Date: _____

Optional MD Printed Name: _____ Signature: _____ Date: _____