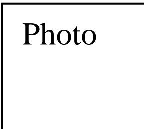
McKinney Independent School District
School Health Services
Individualized Health Plan, Seizure



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:________________________

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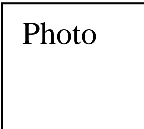

Student's Name:____

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:
   - Seizure is different from usual type or frequency or has not occurred at school in past month
   - Seizure meets criteria for 911 emergency call
   - Student has not returned to "normal self" after 60 minutes
   - 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
(HEALTH SERVICES USE ONLY)

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: _________