

## MSAD 15 Individualized Health Plan for Students with Seizures

Name of Student \_\_\_\_\_ Classroom Teacher \_\_\_\_\_

Student's Date of Birth \_\_\_\_\_ Date this form is being completed \_\_\_\_\_

### Seizure History

Date of First Seizure \_\_\_\_\_

Has this student ever needed to be transported via Rescue to the hospital for management of a seizure?

( ) Yes ( ) No

If yes, please provide details: \_\_\_\_\_

### Seizure Description

How frequently do seizures occur? \_\_\_\_\_

What tends to trigger a seizure? \_\_\_\_\_

How long do the seizures last? \_\_\_\_\_

Does the student experience anything prior to the seizure? ( ) Yes ( ) No

If yes, please provide details: \_\_\_\_\_

Does the student stop breathing during a seizure? ( ) Yes ( ) No

Does the student lose control of his/her bladder or bowels during a seizure? ( ) Yes ( ) No

If yes, please circle which or both.

**Please provide the school with a change of clothes in the event that this occurs at school.**

Please describe the details of a typical seizure for this student: \_\_\_\_\_

### Seizure Management

Is this student taking any medication to help control the seizures? ( ) Yes ( ) No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does this student have emergency medication prescribed to be used in the event of an unusually severe seizure? ( ) Yes ( ) No

If yes, please list name of medication \_\_\_\_\_

Please list circumstances under which this medication should be administered:

\_\_\_\_\_

\_\_\_\_\_

Name of Student \_\_\_\_\_

**In the event of a seizure at school, the MSAD 15 staff will**

1. Stay with the student
2. Contact the School Nurse / Nurse Assistant immediately
3. Place phone call to parents/guardians immediately
4. Protect the student from injury (remove hard/sharp objects in the immediate area)
5. Protect the student's airway (nothing will be put in the student's mouth; the student will be positioned on his/her side)
6. Other students in the room/area will be taken to another room
7. The School Nurse or the Nurse Assistant under the supervision of the School Nurse will assess the clinical status of the student (monitoring vital signs, color, level of consciousness, etc)
8. The School Nurse or the Nurse Assistant under the supervision of the School Nurse will administer physician prescribed emergency medication if indicated
9. In the event that a seizure lasts more than 5 minutes, or if the student's clinical status is such that it is indicated, the Rescue Unit will be called for possible transport to the hospital.
10. Track the details of the seizure on a log form. Copy will be sent home.
11. Other interventions specific to this student: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Emergency Contact Information**

School will attach Emergency Health Information Form to this IHP for quick access in the event of a seizure.

**Authorization to Share Information with Student's Physician / Health Care Provider**

I authorize MSAD 15 Staff to contact my child's physician / health care provider with questions and concerns concerning the management of my child's diagnosis of seizures. I understand that I will be notified of any communication between the school and the physician / health care provider.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Dunn School  
667 Morse Road  
New Gloucester, ME 04260  
Phone 657-5050  
FAX 657-7068

Russell School  
8 Gray Park  
Gray, ME 04039  
Phone 657-4929  
FAX 657-2286

Memorial School  
86 Intervale Road  
New Gloucester, ME 04260  
Phone 926-4322  
FAX 926-4324

GNG High School  
10 Libby Hill Road  
Gray, ME 04039  
Phone 657-9330  
FAX 657-3329

GNG Middle School  
31 Libby Hill Road  
Gray, ME 04039  
Phone 657-9430  
FAX 657-5219