HUMBLE ISD HEALTH SERVICES

SEIZURE MANAGEMENT PLAN

STUDENT _____ ID _____ GRADE _____ DOB _____
PARENT _____PHONE_____ (2) _____
PHYSICIAN_____PHONE_____
MEDICAL HISTORY (OTHER THAN SEIZURES) _____

SEIZURE INFORMATION

TYPE	LENGTH	FREQUENCY	DESCRIPTION

Warning signs_____

Medications:

DAILY MEDICATION	STRENGTH	DOSE	ROUTE	TIME	OTHER INFO

General procedure

- Remain calm
- Notify the nurse
- Track time – Seizure Flow Sheet
- Lay the student on side
- Clear area of harmful objects
- Do not Restrain
- Monitor vital signs
- After _____ call 911
- Initiate CPR if necessary
- Observe for beginning of another seizure

EMERGENCY PROTOCOL –
When seizure (tonic/clonic) last more that 5 minutes
Repeated seizure without regaining consciousness

Student is injured
Respiratory Distress
First time Seizure
Student is injured

→ 911

EMERGENCY MEDICATION –IF AVAILABLE

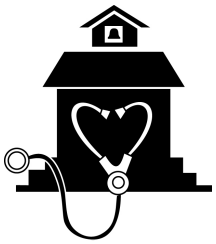
Medication	Strength	Dose	Route	Other Info

☐ Student has a **Vagus Nerve Stimulator** (VNS)
Magnet Orders_____
_____

Physician _____ Date_____
Parent signature below indicates consent to administer medication above and consent for Humble ISD staff to communicate with the physician listed above regarding any aspect of the student's care plan

Parent_____ Date_____
Signature

HUMBLE INDEPENDENT SCHOOL DISTRICT
HEALTH SERVICES



Seizure Health History/Assessment Form

Date:_____
Campus:_____

Student Name:_____ Student ID:_____ Date of Birth:_____
Parent/Guardian:_____Home Phone:_____
Work Phone:_____ Cell Phone:_____
Physician:_____ Phone:_____

1. Does your child have a diagnosis of seizures from a healthcare provider: ☐ **No** ☐ **Yes**

2. History of Current Status

a. Are there triggers for your child's seizures? ___yes ____no
If so, explain: _____
_____
_____

b. What type of seizures does your child have? _____
_____

c. Please list all medications your child takes: _____
_____
_____
_____

d. Age of student when seizures first began:_____

e. How often does your child have a seizure?
_____
_____
_____

f. Describe past seizure(s):_____
_____
_____
_____

g. Over time, are the seizures: ☐Same ☐Better ☐Worse

3. Symptoms

a. What are the early signs and symptoms of your student's seizure? *(Be specific; include things the* student *might do.)*_____
_____

b. How does your child communicate his/her symptoms?_____

c. How long do the seizures usually last: _____secs. _____mins.

d. Please check the symptoms that your child has experienced in the past:

Skin	**Mouth**	**Limbs**	**Throat/Face**	**Lungs**	**Heart**
☐ Pale	☐ Twitching	☐ Jerking	☐ Choking	☐ Difficulty breathing	☐ Weak pulse
☐ Flushing	☐ Pulls to side	☐ Stiffening	☐ Staring	☐ Stops breathing	☐ Loss of Consciousness
☐ Lips turn blue		☐ Flailing	☐ Blank Look		
☐		☐ Drop/Atonic	☐ Unresponsive to Commands		
☐					

4. Treatment

a. How have past seizures been treated?_____
b. What was the student's response to treatment?_____
c. Was there an emergency room visit? ☐ No ☐ Yes, explain:_____
d. Was the student admitted to the hospital? ☐ No ☐ Yes, explain:_____
e. What emergency treatment or medication has your healthcare provider recommended for use in a seizure?_____
_____
f. Has your healthcare provider provided you with a prescription for this medication? ☐ No ☐ Yes
g. Have you ever used the emergency treatment or medication? ☐ No ☐ Yes

h. Please describe any side effects or problems your child had in using the suggested treatment:_____

_____

5. Family/Home

a. How do you feel that the whole family is coping with your student's seizure disorder? _____

_____

b. Do you or your child carry emergency medicine in the event of a seizure? ☐ No ☐ Yes

c. Has your child ever needed the emergency medicine away from home? ☐ No ☐ Yes

d. Do you feel that your child needs assistance in coping with his/her seizure disorder?_____

6. General Health

a. How is your child's general health other than having a seizure disorder?_____

b. Does your child have other health conditions? _____

c. Has your child ever been hospitalized for any reason?_____

d. Please add anything else you would like the school to know about your child's health:_____

_____

7. Notes:

_____

Parent/Guardian Signature:_____ **Date:**_____

Reviewed by:_____ **Date:** _____

Humble Independent School District Health Services

Authorization and Permission for Administration of Medication

☐ In eSchool
Nurse Initial_____
Expiration Date
_____

Guidelines for acceptance and administration of medications in Humble ISD are available from the campus nurse.

Students Name_____ **DOB**_____
Last **First** **MI**

PARENT/GUARDIAN SECTION

Medication name **Strength** **Dosage** **Route** **Time**

Start Date_____ Allergies_____

Special Instructions/Duration_____

Condition for which drug is to be given_____

Medications currently taken at home_____

Note: Non-prescription medications taken more than 4 times in a month and prescription PRN medication will require a physician's order (signature is required) indicating maximum dosage allowed per month.

PARENT: PLEASE SIGN AT THE BOTTOM OF THE MEDICATION FORM

PHYSICIAN'S SECTION: PLEASE WRITE ORDER FOR SCHOOL ADMINISTRATION

Parent approval for release of information indicated below. Prescription medication given more than 10 days, non-prescription medication given more than 4 times in a month, or in excess of recommended dosage on the container and all prescription PRN medications require a physician's order.

Medication name **Strength** **Dosage** **Route** **Time**

Start Date_____ Allergies_____

Special Instructions/Duration_____

Condition for which drug is to be given_____

Medications currently taken at home_____

Physician's name (print)_____ **Physician's signature**_____

Phone number_____ **Fax number**_____ **Date**_____

I request the above named student be given the medication at school by qualified staff, according to the prescription or non-prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the physician as needed and that medication information may be shared with school personnel who need to know. I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication.
Completion of this form acknowledges your review of and agreement to follow all district medication guidelines.

Parent's Signature _____ **Date**_____
Daytime Phone_____ Alternate phone _____

Humble Independent School District Health Services

Authorization for Release of Medical Records

Student_____ DOB_____ Date_____

Campus_____ Grade_____

I grant permission for the release of medical information and physician recommendations as it pertains to the student's accommodations which will allow for participation in the educational process with minimal disruption.

Information requested_____

_____

_____

From: (Physician Name & Address)

_____

_____

_____

_____

To: (School Nurse)

_____

_____

_____

_____

_____ _____

Signature of Parent/Guardian, (Student if 18 years or older)

Date

The mission of Humble ISD Health Services is to enhance the health and well being of the students, staff, and community thus supporting the education of all students through maximizing their educational time.