Individualized Healthcare Plan

Identifying Information

Student Name: _____DOB:_____

Teacher/Grade: _____

Mother's Name: _____Phone#_____

Father's Name: _____Phone#_____

Physician

Physician: _____ Office #: _____

Physician Address: _____

Hospital of Choice: _____

Emergency Contact (in addition to or different from above)

Name: _____ Relationship: _____

Phone #: _____

Name: _____ Relationship: _____

Phone #: _____

Medical Overview

Circle Medical Condition(s):

Asthma **Food Allergy** **Environmental Allergy** (ex: bee stings) **Diabetes**

Cardiac **Seizure** **Other:_____**

This IHP is for one school year. I, the parent/guardian of _____ give consent to release the information contained in the IHP to all staff members who will care for my child or who may need to know this information to maintain my child's health and safety. I will notify the school nurse immediately if the health status changes, there is a change of physicians, or there is a change or discontinuation of medications or procedures. I agree to provide medical equipment, supplies, and medication as needed for the care of my child. By signing one time below, and initialing each needed page, I am in agreement with all instructions, treatments, procedures, medications, & action plans attached.

Parent/Guardian Signature/Date: _____

Parent/Guardian initials: _____

Seizure Individualized Health Plan/Medication Orders

Student Name: _____Grade:_____DOB:_____

Medications to be given at School (name/dose/route):

_____

Dates to be given_____ Relevant side effects: _____

Medications taken at Home:_____

Classification of Seizure: _____

Triggers: _____

Usual signs & symptoms of seizure: _____

Vagus Nerve Stimulator? Yes No

Location:

Persons trained to use:

Describe magnet use:

Plan of Action When Seizure Occurs:

1. Note time of seizure onset
2. Assist student to floor. Clear nearby area of hazards.
3. Place head on padded surface and loosen restrictive clothing
4. DO NOT RESTRAIN OR PLACE ANYTHING IN MOUTH
5. Turn student onto side to prevent aspiration of oral secretions
6. Note type and progression of seizure; also note student's color, breathing, pulse, and level of consciousness
7. If seizure persists longer than 5 minutes, or a second seizure begins shortly after the first, or student is not breathing, CALL 911. Provide first aid and CPR as needed and notify parent immediately
8. Monitor student until the seizure concludes and student is alert/oriented
9. Provide for personal hygiene and privacy as appropriate. If student is tired after the seizure, allow to rest in a supervised area as needed
10. Notify parent as soon as possible

Other Instructions:

_____

_____

Physician signature: _____Date_____

Parent/Guardian signature: _____ Date _____