SUMTER County Health Services

INDIVIUAL SEIZURE ACTION PLAN (ISAP)

STUDENT/CONTACT INFORMATION

Student Name:		DOB:	Date Diagnosed:
School Year: -	Effective Date:	School:	Grade:
Parent/Guardian #1:	Primary #:	Secondary #:	Email:
Parent/Guardian #2:	Primary #	Secondary #:	Email:
Other Emergency Contact:	Primary #	Secondary #:	Relationship:
Primary Care Provider/Pediatrician:		Phone #:	Fax #:
Seizure/Epilepsy Healthcare Provider:		Phone #:	Fax #:
Preferred Hospital:			

SEIZURE INFORMATION COMPLETED BY PHYSICIAN

Use the area below to provide a brief description of what student seizures usually look like and recommended care

Seizure Type	Length of Seizure	Frequency of Seizure	Description

Seizure triggers or warning signs:	**Student's response after a seizure:**

Recommended care at school

SEIZURE MEDICATIONS COMPLETED BY PHYSICIAN

List medication (daily or rescue) taken at school

Allergies:

Emer Med	Name of Medication	Dose	Route	Frequency	Special Instructions	School Med

Any medication given at school require a separate Medication Authorization/Treatment Form to be completed by the physician for each medication. Access form at www.sumter.k12.fl.us student services and Assessment, physician order

VAGUS NERVE STIMULATOR COMPLETED BY PHYSICIAN

Does student have a **Vagus Nerve Stimulator (VNS)?** ☐ **Yes** ☐ **No**

If yes, where does the student keep the magnet?

Special instructions for **Vagus Nerve Stimulator**: Give _____ swipes. Wait _____ min. between swipes.

Student Name:_____

ACCOMMODATIONS AT SCHOOL COMPLETED BY PHYSICIAN

Please list any accommodations, special considerations, or precautions the student needs at school.

Diet:
School Trips:
After-School programs or activities:
Sport/PE:
Bus:
Other school related activities:

STUDENT'S ABILITY COMPLETED BY PHYSICIAN

Student is aware of seizure/epilepsy diagnosis? ☐ Yes ☐ No
Student is aware of seizure triggers and warning signs? ☐ Yes ☐ No
Student is aware of daily and as needed medications for seizures? ☐ Yes ☐ No
If student has Vagus Nerve Stimulator student knows magnet location? ☐ Yes ☐ No
If student has a Vagus Nerve Stimulator student knows how to use if able? ☐ Yes ☐ No

BASIC SEIZURE FIRST AID BY PHYSICIAN

If student seizure lasts less than 5 minutes and is normal for the student can follow the procedure below:

☐ **Convulsive Seizure Disorder**

Notify school nurse and administration if not already present. Help the student to the floor if failing and position on side. Loosen restrictive clothing and remove glasses or other objects that may cause injury. Clear the area around the student to protect from injury. Cushion students head. **TIME THE SEIZURE. DO NOT RESTRAIN** unless doing so is necessary to prevent injury. **DO NOT PUT ANYTHING IN THE MOUTH.** Notify parent or guardian of any seizure activity. Monitor for continued or prolonged seizures. Offer reassurance when consciousness returns. Allow student to rest.

☐ **Non-convulsive Seizure Disorder**

Do not leave the student suspected of being in a state of confusion or non-responsiveness alone. Ensure student is in a safe environment. **Do not restrain** unless doing so is necessary to prevent injury. Never assume that the student heard or understood the instructions given. Call parent/guardian. Notify nurse.

Special Considerations or Instructions:

STUDENT SPECIFIC SEIZURE FIRST AID BY PHYSICIAN

- **If student seizure last longer than _____ minutes**
- **Call EMS/911 Check circulation, airway, breathing, and initiate the steps of CPR as needed. Provide emergency medications as ordered by physician.**
- **If a seizure lasts longer than _____ minutes the school nurse or trained unlicensed personnel can administer the following medications:**

.Any medication given at school require a separate Medication Authorization/Treatment Form to be completed by the physician for each medication. Access form at www.sumter.k12.fl.us student services and Assessment, physician order

Name of Medication	Dose	Route	Special Instructions

Offer reassurance when consciousness returns. Let the student rest. Notify parent or guardian

Special Consideration or Instructions:

Student Name:_____

SIGNATURES/PARENTAL CONSENT

This Individual Seizure Action Plan has been approved by:

OFFICE STAMP HERE

Primary/Seizure Healthcare Provider Signature and Date:_____

Parent Signature and Date:_____

I (parent/guardian) understand that the student may perform all treatments and procedures and/or trained unlicensed assistive personnel within the school or by EMS in the event of loss of consciousness or seizure. I also understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures. I have reviewed this ISAP and agree with the indicated instructions. This form will assist the school health personnel in developing a nursing care plan.

I consent to the release of the information contained in this ISAP to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I give permission for the school nurse/personnel, to contact my child's healthcare provider, if needed to provide continuity of care.

This plan will remain in effect until the parent submits a revised ISAP to the school.

School RN:_____ Date:_____