Seizure Individualized Healthcare Plan (IHCP)

Student:_____ID#: _____
Grade:_____DOB:_____Teacher: _____
Allergies: _____
Student's Secondary Health Concerns: _____

Nursing Diagnosis: Knowledge Deficit Related to Seizure Disorders & Prescribed Treatment Regimen (NANDA 00126)
Risk for injury related to seizure disorder (NANDA 00035)
Student Goal: Student will demonstrate understanding of the disease process and management.
Student will remain free of physical injury during a seizure.

Ratings: 1- No Knowledge, 2- Limited, 3- Moderate, 4- Substantial, 5- Extensive Knowledge, N/A- Not Applicable (Circle One)

Student Knowledge: Disease Process

	Date:_____	**Date:_____**	**Date:_____**	**Date: _____**
Able to Identify Known Triggers/Risk Factors	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Able to Describe Common Signs & Symptoms of the Disease	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Describe Potential Complication of Disease	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Verbalizes Lifestyle Changes that may be Required to Prevent/Control Future Complications of Disease	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

Student Knowledge: Treatment Management

Knowledge of Treatment Regimen	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Knows Importance of Continual Access to Emergency Medication	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Verbalizes Understanding on When to Use Prescribed Medication	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

Knows When to Seek Medical Attention/Emergency Treatment	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A
Understands treatment effectiveness	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A
Routinely monitors expiration date	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A

Student Knowledge: Medication Administration

Identification & Correct Name of Medication	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A
Correct Use of Prescribed Medication (Correct Dose, Time, Route)	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A
Able to Verbalize Medication Side Effects	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A
Confidence Performing Needed Task	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A

Ratings: 1- Severely Compromised, 2- Substantially, 3- Moderately, 4- Mildly, 5- Not Compromised, N/A- Not Applicable (Circle One)

RN Assessment of Student Health Status

Physical Health	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A
Mental Health	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A
School Attendance	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A
Readiness to Learn	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A
Participation In Physical Activities	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A
Healthy Dietary Habits	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A	1	2	3	4	5	N/A

Completed by:	**Completed by:**	**Completed by:**	**Completed by:**
Nurse's Signature:	**Nurse's Signature:**	**Nurse's Signature:**	**Nurse's Signature:**

***Emergency Action Plan Available in Medication Binder, UAP & Student Checklists Completed by RN**

Additional Notes: _____

School Health Program

Student Checklist for Seizure Control

Student Name: _____

School Nurse: _____ **Date:** _____

The student has demonstrated understanding and competency consistently to:

SKILLS	YES	NO	COMMENTS
I. Identify triggers for seizure			
2. State the name of the medication			
3. State the purpose for the medication			
4. State knowledge of medication: A. Side effects B. Adverse reactions C. Proper storage			
5. State need to call 911			
6. State the signs of precipitating seizure (Aura)			

The student agrees to follow the safety precautions with medication compliancy and to report any precipitating factors whenever possible.

Student Signature_____ Date: _____

Parent Name/Signature_____ Date_____

I hereby acknowledge that the student listed above has demonstrated all the above listed skills.

School Nurse Signature_____ Date_____

Review Dates: _____ _____ _____ _____ _____ _____ _____

School Health Program

Skills Checklist for Delegation to Unlicensed Assistive Personnel

Student Name: _____

School Nurse: _____ **Date:** _____

Trainee Name: _____

The trainee has demonstrated understanding and competency consistently to:

SKILLS	YES	NO	COMMENTS
I. Identify seizure triggers for student			
2. Identify signs and symptoms of seizure episode			
3. State use of medication: A. Correct name and expiration date B. Side effects C. Adverse reactions D. Appropriate use of medication per order			
4. State safety precaution measures			
5. State the location and content of the Emergency Healthcare Plan (ECP)			
6. State when to call 911			

Trainee Signature_____ Date: _____

I hereby acknowledge that the person listed above has demonstrated all the above listed skills safely.

School Nurse Signature_____ Date_____

Review Dates: _____ _____ _____ _____ _____ _____

School Health Program

Skills Checklist for Delegation to Unlicensed Assistive Personnel

Student Name: _____

School Nurse: _____ **Date:** _____

Trainee Name: _____

The trainee has demonstrated understanding and competency consistently to:

SKILLS	YES	NO	COMMENTS
I. Identify seizure triggers for student			
2. Identify signs and symptoms of seizure episode			
3. State use of medication: A. Correct name and expiration date B. Side effects C. Adverse reactions D. Appropriate use of medication per order			
4. State safety precaution measures			
5. State the location and content of the Emergency Healthcare Plan (ECP)			
6. State when to call 911			

Trainee Signature_____ Date: _____

I hereby acknowledge that the person listed above has demonstrated all the above listed skills safely.

School Nurse Signature_____ Date_____

Review Dates: _____

FLORIDA DEPARTMENT OF HEALTH IN MIAMI-DADE COUNTY
SCHOOL HEALTH PROGRAM
ROLES & RESPONSIBILITIES – SEIZURE DISORDER

Student:_____DOB_____Teacher:_____Grade:
_____Parent/Guardian & Phone(s):_____School Year: _____

Follow the attached physician action plan; if no plan submitted, call 911 and parent/guardian.

School Responsibilities/Agreements	Family Responsibilities/Agreements	Student Responsibilities/Agreements
1. Medication Kept:	1. Provide medication authorization and correctly labeled medication for school site at beginning of school year/annually and as necessary.	1. Able to report early warning signs of a seizure, "Aura".
2. Trained staff (2) to administer medications per Authorization for Medication: - -	2. Inform school staff of any changes to medications Provide new medication authorization and labeled medication Replace expired medications ASAP	2. What are the student's early signs and symptoms of a seizure?
3. Staff to contact 911/parent/guardian:	3. Inform school staff of any changes in student's condition/limitations	
4. Staff to direct EMS to the emergency:	4. Parent or designated adult, as noted on emergency alert card, to respond to school when called. → Maintain current and up to date phone numbers	
5. CPR certified staff (2):		
6 Substitute teacher instructions:		

_____ _____
Parent/Guardian Signature Date

_____ _____
Principal or School Administration Designee Date

_____ _____
School Nurse Date

8020 & 8080
Child-Specific Training for School Staff
August 20____- June 20_

School:_

Student:_ **Date_**
ID # _
DOB:_
Health Condition:_

Teacher Name	Subject	Signature	Level 2	Level 3

School Nurse:_