JOHNSON CITY SCHOOLS - HEALTH SERVICES
INDIVIDUAL HEALTH PLAN (IHP) – CONFIDENTIAL

SEIZURES

Student Information:

Name of Student: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Emergency Information:

Parent(s') Names: _____

Phone Number: _____ Phone Number: _____

Primary Care Physician: _____ Specialist: _____

Phone Number: _____ Phone Number: _____

Fax Number: _____ Fax Number: _____

In the event a parent/guardian cannot be reached:

Name: _____ Relation: _____ Phone Number: _____

Name: _____ Relation: _____ Phone Number: _____

If a seizure occurs:

- Stay Calm
- Turn person to side to ensure clear airway
- Note time seizure started
- Provide Privacy
- Do Not restrain or put anything in mouth
- Protect from injury
- Give rescue medication
- Observe Breathing
- Administer CPR if Necessary

Medical Information – Must be complete by Physician's Office

Please describe student's seizures (include type of seizure, signs prior to, during and after): _____

_____

Current seizure management plan: _____

_____

Current Medications: _____

_____

Any chronic illnesses/disabilities/special considerations: _____

_____

_____

Allergies: _____

Are there any interventions in addition to the ones listed in the "Seizure Emergency Protocol" that would assist student before, during or after a seizure? If so, please list: _____

_____

Physician's Signature: _____ ***Date:*** _____

I, the parent or guardian of the above student, request that this Individual Health Plan (IHP) be administered to my child. I understand that it is my responsibility to provide the school with the necessary supplies and medication and will notify the school if there is any change to my child's health status. I agree to provide a new consent for any changes in doctor's orders and authorize the school nurse. To communicate with the physician when necessary. I understand that this information will be shared with the appropriate members of the educational team.

Parent's/Guardian's Signature: _____ Date: _____

Reviewed by: _____ Date: _____