Central Community Unit School District 301
Dr. Todd Stirn, Superintendent

Student Services Department, Health Services Division

Dear Parents/Guardians:

The Nursing Department of Central CUSD 301 is committed to promoting your student's ability to learn through optimal health and well-being. Our mission is to assist students in establishing successful management of health conditions and facilitating growth in independent care while maintaining safety.

Seizures can affect a student's ability and performance during school. In order to promote student success, comply with government regulations, and establish an effective individual healthcare plan (IHP), district personnel work closely with students, families and healthcare provider(s). The following guidelines have been adopted by the district for students diagnosed with seizures:

An **Individual Healthcare Plan (IHP) is required** for all students who have a seizure diagnosis.

- If medicine is to be available or given at school, the Healthcare Provider Orders – Med-A form is also required.

Additional forms you may be asked to complete include:
-- A Questionnaire: which gathers historical information about your child's condition;
-- An Authorization to Release Records: needed to communicate & collaborate with the healthcare provider(s).

Forms can be found on the District website by visiting the Health Services Department webpage. To download and print forms, hover over the Health Services tab on the left side, then select Health Requirements. Scroll down to find the link to the Seizure Packet.

Please have necessary documents completed and call the nurse at your child's school to schedule a meeting to review documents and implement the plan.

Respectfully,

Central CUSD 301 Health Services Staff

	CHS	CMS	PKMS	HBT	CT	PV	LL
Ph	847-464-6030	847-464-6000	847-717-8100	847-464-6008	847-717-8000	847-464-6014	847-464-6011
Fax	847-464-6039	847-464-0233	847-717-8105	847-464-6022	847-717-8006	847-464-6024	630-365-2283

Central Community Unit School District 301

Department of Student Support Services – Health Services Division

Individual Healthcare Plan for Student with Seizure Disorder

Photo Here

Name: _____ D.O.B. _____

School _____ Grade _____ Homeroom _____ School Year _____

Medical History _____

Triggers _____

Seizure Type & Description _____

Warning Signs _____

Basic First Aid for this student: _____

Other:

Does student need to leave the classroom after a seizure? Yes No
If Yes, describe process for returning student to classroom:

A Seizure Emergency for this child is: _____

Protocol: (Check all that apply & clarify)

- ☐ Contact nurse
- ☐ Call 911 if _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications _____
- ☐ _____
- ☐ _____

Basic First Aid: Care, Comfort, Calm

Track time, onset & length
Contact nurse
Keep child safe
Monitor breathing / keep airway open
To avoid falls, gently guide to floor; turn on side
Protect / cushion head
Do not restrain
Do not put anything in mouth
Stay with child until fully conscious
Remove other students from area
Monitor & record observations in seizure log

A Seizure is generally considered an Emergency when:

Convulsive seizure lasts longer than 5 minutes
On a bus
Student has breathing difficulties
Seizures repeat without regaining consciousness
Student is injured or has diabetes
It is a first-time seizure
It occurs in water

Routine & Preventive Meds

Medication	Dose/Time/Route	Home/School

Special Considerations & Precautions

_____
_____
_____
_____

Vagus Nerve Stimulator? Yes No Describe magnet use: _____

_____

Contact Information

Name	Relationship	Phone Number(s)
#1		
#2		
#3		

_____ Healthcare Provider _____ Bus # am _____ Bus # pm _____

I give permission for this care plan to be in place at school and for the medications ordered herein to be administered by school staff.
I further consent to sharing this plan with administrators, teachers, bus drivers & other school personnel who may need to know.

Parent/Guardian Signature _____ Date _____

Student Signature if emancipated _____ Date _____

Signature of Nurse _____ Date _____

Fax to: Central CUSD 301 Health Services:

CHS	CMS	PKMS	HBT	CT	PV	LL
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Central Community Unit School District 301
Department of Student Services – Health Services Division

Healthcare Provider Orders - **Med-A** for Students with **Seizures**

Name of Student _____ Date of Birth:_____

School _____ Grade ____ Homerm_____ School Year _____

Diagnosis/seizure type: _____

Medications student takes **at home**: _____

Triggers/situations to avoid: _____

_____

Medication orders for School

Medication Name	Dose & Frequency	Route	Possible Side Effects / Other
Routine:			
Routine:			
Other:			
EMERGENCY:			

Further orders: _____

Are these medications necessary to maintain the student at school? Yes No

What constitutes a seizure *emergency* for this child? _____

Does student have a Vagal Nerve Stimulator? Yes No If Yes, describe use:_____

_____

Doctor Name _____ Ph#_____ Fax #_____
(please PRINT)

Practitioner/Physician Signature _____ Date _____

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