Seminole County Public Schools Health Services

# INDIVIDUALIZED SEIZURE ACTION PLAN (I-SAP)

An I-SAP must be developed and signed by a licensed healthcare provider, in consultation with the student's parent/guardian every school year.

| | | | |
|---|---|---|---|
| **Student Name:** | **DOB:** | **School:** | **School Year:** |
| **Grade:** | **Height:** | **Weight:** | **Date I-SAP filled out (today's date):** |
| **Parent/Guardian #1:** | **Primary #:** | **Secondary #:** | **Email:** |
| **Parent/Guardian #2:** | **Primary #:** | **Secondary #:** | **Email:** |
| **Other Emergency Contact:** | **Primary #:** | **Secondary #:** | **Relationship:** |
| **Healthcare Provider Completing this I-SAP:** | | **Phone #:** | **Fax #:** |

| | | |
|---|---|---|
| **Epilepsy/Seizure Diagnosis/Type:** | **Age at diagnosis:** | **Date Diagnosed:** |
| **Description of Seizure Activity/Symptoms (include duration):** | **Frequency:** | |
| **Current Medications/Diets/Devices/Treatments:** | **Known Allergies:** | |
| **Student's level of awareness/understanding AND ability to manage of his/her disorder:** | | |

**<u>Before a seizure emergency occurs:</u>**

**<u>During a seizure emergency:</u>**

Student Name _____

**After the seizure emergency has ended:**

**When to call emergency services (911/EMS) or go to the emergency department:**

**Communications:**

**Accommodations:**

## MEDICATION / PROCEDURE ORDERS

☐ **Medication Authorization** (#1): Describe the type and duration of the seizure that require the administration of the medication listed below:

| | | | | |
|---|---|---|---|---|
| | Type: | | Duration: minute(s) | |
| | Medication: | Strength: | Dose: | Route: |
| | Additional administration instructions: | | | |
| | List any significant side effects to this medication: | | | |

☐ **Medication Authorization** (#2, if needed): Describe the type and duration of the seizure that require the administration of the medication listed below:

| | | | | |
|---|---|---|---|---|
| | Type: | | Duration: minute(s) | |
| | Medication: | Strength: | Dose: | Route: |
| | Additional administration instructions: | | | |
| | List any significant side effects to this medication: | | | |

☐ **OXYGEN Administration Orders**:

**INDIVIDUALIZED SEIZURE ACTION PLAN (I-SAP)**

Student Name _____

☐ **VNS Authorization:** Describe the type and duration of the seizure that require the administration of the Vagus Nerve Stimulation procedure below:

| Type: | Duration: minute(s) |
|---|---|

If the student is having a seizure as described above, the following actions are to be taken.

1. At the start of the seizure, remove the magnet from its storage device.
2. Swipe the magnet slowly over the generator located in the left upper chest, moving it from the left shoulder to the right.
3. Wait one minute for a response.
4. If no response, the process can be repeated _____ times.
5. If the seizure activity lasts longer than _____ minutes, **call 911**.

☐ **OTHER CONSIDERATIONS**:

☐ **NO** medication or procedure is requested at school. In case of an emergency, please provide general or seizure first aid and

This Individualized Seizure Action Plan has been approved by:

Provider stamp

**Healthcare Provider Signature:** _____

Date: _____

The following section is to be reviewed and completed by a parent/legal guardian:

- I (parent/guardian) have reviewed this plan and agree with the indicated instructions. This form will assist the school health personnel in developing a nursing care plan. Therefore, I consent to the release of the information contained in this Individualized Seizure Action Plan 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 hereby grant permission to Seminole County Public Schools and its designees to assist in the administration of the above-prescribed medication to my child while in school and during school sponsored activities (FS 1006.062).
- I also give permission to the school nurse or authorized school personnel to contact my child's healthcare provider when necessary or regarding administration of the above medication(s) and/or procedure.
- I understand that the school is not responsible for damage, loss of equipment, or expenses utilized in these treatments and procedures.
- It is my responsibility to provide new authorization (updated I-SAP) if and when these orders change.
- I understand that I must supply the above prescribed medication, oxygen or VNS magnet to the school and know that medication must be in the container in which it was purchased. Prescription medications must have a pharmacy label attached that matches this authorization.
- I understand that in any emergency situation, the school reserves the right to call 911, and I understand that in all instances wherein emergency medication is administered 911 will be called to evaluate my child. I further understand that if EMS determines my child does not need to be transported to the hospital, it is my responsibility to arrange for my child to be picked up from school immediately (within 30 minutes) for follow-up monitoring.

**Parent Signature:** _____ Date: _____

**School RN:** _____ Date: _____

Student Name _____