Huron Valley Schools – Plan of Care (POC)
Seizure Management

Bus Route #: _____

Student Name: _____ School: _____ Grade: _____

Prior to having a seizure, the following warning or behavioral changes may occur:
(Doctor, please write the type of symptoms specific to the student prior to having a seizure.)

During a seizure, the student will exhibit the following behaviors:
(Doctor, please write the type of symptoms specific to the student during a seizure.)

If you observe the student having a seizure:

- Note the time
- Clear the area to protect the student

Call 911: ☐ Immediately ☐ If seizure lasts longer than _____ minutes.
Administer Diastat after _____ minutes.

Monitor closely until help arrives.
Call parents immediately.
Get medication list from student's file.

Call Parents: Home Phone: _____

Mother: _____Cell Phone: _____Work Phone:_____

Father: _____Cell Phone: _____Work Phone:_____

In the event that special accommodations are required, the school district may need up to five (5) school days to comply with the request. It will be up to the parent and the physician to determine if the child shall attend school during that time.

_____ _____ _____ _____
PARENT SIGNATURE DATE PHYSICIAN SIGNATURE DATE

Physician Name _____

Physician Address_____

Physician Phone _____