Individualized Healthcare Plan- Seizures

School Year___________
School ______________
Bus/Walk ____________

Student____ Date of Birth_________________________
First Last
Parent(s)/Guardian(s):____

Home Phone__________________ Work Phone__________________ Cell /Pager__________________

Health History:____
____

Medications: ____
Allergies to medications: ____

Seizure Type: ☐ Tonic- Clonic (grand mal) ☐ Petit mal ☐ Other ______________________

Frequency: ____________________ **Length** __________________

Description ____

Seizure triggers or warning signs: ____

Student's response after a seizure: ____

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth

For tonic-clonic seizure

- Protect head
- Keep airway open/ watch breathing
- Turn child on side

Call 911, for the following:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has first time seizure
- Student has breathing difficulties
- Student has a seizure in water

Special considerations and precautions (regarding school activities, sports, field trips, transportation/bus etc.):
____
____

An up-to-date school district medication administration permission form signed by parent/guardian must be on file in the school office for all medications that are to be administered at school.

I give permission to the school nurse and other properly trained and authorized staff members of the Philomath School District 17J to perform and carry out the tasks as outlined by my child's seizure care plan. I also consent to the release of the information pertaining to my child's health care to the staff members who have custodial care and those who may need to know this information to maintain my child's health and safety during the school day.

Parent/Guardian Signature ________________________________ Date ______________

Please return this completed form to the office at your child's school.

Philomath Public Schools
2021 Chapel Drive
Philomath, OR 97370-9632

Seizure Questionnaire

According to our records your child has seizures. To provide a safe educational environment it is necessary to have current health information on file. Please use this questionnaire to update your child's health information and return it to the school nurse at the district office. This information will be used to create or update a health management plan that will be shared with Philomath School District personnel who will be directly participating in the education and/or safety of your child.

Student Name ______________________ DOB ____________
Parent/Guardian #1 ______________________ Relationship ____________
Home # ____________ Work # ____________ Cell # ____________
Parent/Guardian #2 ______________________ Relationship ____________
Home # ____________ Work # ____________ Cell # ____________
Other Emergency Contact ______________________ Relationship ____________
Home # ____________ Work # ____________ Cell # ____________
Neurologist ______________________ Phone # ____________

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? ____________
2. When was your child's last seizure? ____________
3. Has there been any recent change in your child's seizure patterns? ____________
   If YES, please explain: ____________
4. Are there any warnings and/or behavior changes before the seizure occurs? ____________
   If YES, please explain: ____________
5. How does your child react after a seizure is over? ____________
6. Has your child ever been hospitalized for a continuous or prolonged seizure? ____________
   If YES, please explain: ____________
7. What type(s) of seizure(s) does your child have?

Seizure Type	Length	Frequency	Description

8. What daily medication(s) does your child take?

Medication	Dosage	Frequency and Time of Day Taken

9. What emergency/rescue medications (if any) are prescribed for your child?

Medication	Dosage	Administration instructions (timing* and method**)

**For seizure clusters, for prolonged seizures, etc.* ***Rectally, under the tongue, etc.*

10. What medication(s) will your child need to take during school hours? ____________
    If yes, please fill out the required Medication at School Permission Form.

The Philomath School District Nurse has my permission to consult with my child's medical providers for information necessary to provide my child with a safe educational environment.

Parent Signature ______________________ Date ____________