Dunlap Community Unit School District #323

Dates Updated:

CONFIDENTIAL

SEIZURE CARE PLAN

Student Name: _____ Date of Birth: _____ School Year: _____

Teacher: _____ Attending School: _____

Grade: _____ DOR: Dunlap Unit SD 323

Contact Information (see attached **Emergency Information Sheet**):

Physician Treating Seizures: _____ Ph#: _____ FAX#: _____

Primary Physician: _____ Ph#: _____ FAX#: _____

Hospital Choice (please check one): ☐ OSF St. Francis ☐ UnityPoint Health - Methodist ☐ Proctor Hospital ☐ Pekin Hospital

Emergency Notification: 911 and you will be called for student in these situations:

* When a seizure does not stop after _____ minutes
* When a seizure happens in or near water
* When the student does not come around or is not breathing properly after seizure
* When another seizure starts soon after the first one ends
* Other:

Type of Seizure:

Description of Seizures (Please check all that apply):

☐ Staring
☐ Remains conscious
☐ Confused
☐ Stiffening (arms/legs)
☐ Eye blinking
☐ Loss of awareness
☐ Unconsciousness
☐ Blue color to lips/skin
☐ Distorted sense of smell, hearing, sight
☐ Rhythmic jerking/twitching on one side
☐ Purposeless, repetitive movements
☐ Loss of bowel or bladder control

Other:

Possible warning and/or behavioral changes prior to seizure:

Average/Usual length of seizure:

Usual time of day seizure occurs:

Date or age of student when first seizure occurred:

Date of last two seizures: 1. _____ 2. _____

Date of last hospitalization for a seizure:

My child wears medical identification: ☐ Yes ☐ No

My child understands what seizures are and what causes them? ☐ Yes ☐ No

My child knows when a seizure may happen? ☐ Yes ☐ No

Seizure Medications (a medication authorization form must be completed for in-school medications):

Drug Name: _____ Dose: _____ Time Given: _____

Drug Name: _____ Dose: _____ Time Given: _____

Drug Name: Dose: Time Given:

List any limitations to student's activities or special equipment needed:

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Student's Name: Date of Birth: School Year:

List other emergency procedures or physician preferences for student experiencing seizure signs/symptoms:

Field Trips:

Teacher will take **Seizure Care Plan** and any equipment/medication needed on field trips along with the student's **Emergency Information Sheet.** Teacher will be instructed on the correct use and procedure for equipment and medication administration.

1. As parent/guardian of , I give permission for this plan to be available for use in my child's school, and for the school nurse to contact the above named physician by phone, fax, or in writing when necessary to complete this plan.
2. It is understood by parents and physician that this plan may be carried out by school personnel other than the school nurse. The school's registered nurse is responsible for the delegation of this plan to unlicensed school personnel when appropriate.
3. This plan will be reviewed annually and/or whenever the health status or medications change and **it is the responsibility of the parent to notify school nurse of these changes.**

Physician Signature _____ Date: _____

Parent/Guardian Signature _____ Date: _____

School Nurse Signature _____ Date: _____

Homeroom Teacher Signature _____ Date: _____

School Staff Signatures _____ _____

School Staff Signatures _____ _____