INDIVIDUAL HEALTH PLAN/EMERGENCY CARE PLAN FOR STUDENT WITH SEIZURES

TO BE RENEWED EACH SCHOOL YEAR

(If you need assistance completing this form, contact the Licensed School Nurse)

Student Name_____ Birth Date _____

School _____ Grade_____ Teacher_____ School Year _____

According to our records, your child has a history of seizures. Completion of this form will keep your child's health record current.

1. **My child has seizures.** ◯ YES **Complete form, sign and date back, and return it to your child's school.**
   ◯ NO ***Parent/Guardian Signature:** _____ **Date:** _____
   (IF "NO" IS CHECKED, DO NOT FILL OUT THE REMAINDER OF THE FORM, BUT SIGN AND RETURN IT TO YOUR CHILD'S SCHOOL.)
2. Check the type of seizure your child has:
   - ☐ Generalized tonic-clonic: Muscles become rigid with convulsive movements and impaired consciousness
   - ☐ Complex partial (focal impaired awareness): May consist of purposeless activity and blank stare
   - ☐ Simple partial (focal aware): Jerking of one limb or side of body, consciousness maintained
   - ☐ Absence: Brief interruption of consciousness often characterized by an appearance of daydreaming
3. **List any known seizure triggers:** _____
4. Describe any warnings and/or behavior changes before the seizure:_____
   _____
5. Any recent changes in your child's seizure patterns: ◯ Yes ◯ No
   If yes, explain:_____
6. Describe what happens during the seizure: _____
   _____
7. Describe what happens after the seizure: _____
   _____
8. How long does seizure last? _____
9. Approximate date of last seizure:
10. How frequent are seizures? ◯ daily ◯ weekly ◯ monthly ◯ yearly
11. Medication your child takes at home for seizures: _____
12. Will your child need any treatment or medication at school for seizures: ◯ Yes ◯ No
    If yes, explain: _____

If medication is needed at school, please complete
"Consent Form For Administration of Emergency Seizure Medication During the School Day"

13. Are there any special considerations or precautions regarding school activities and field trips. ◯ Yes ◯ No
    If yes, explain: _____
14. Health Care Provider Name: _____Phone #_____
    Clinic: _____ Fax #_____
15. Contact parent/guardian or alternative contact person. *(List in order of who to call first)*
    Name: _____ Relationship: _____ Daytime Phone: _____ Cell: _____
    Name: _____ Relationship: _____ Daytime Phone: _____ Cell: _____
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-OVER-

Student Name _____

SCHOOL ACTION/EMERGENCY PLAN

If student has a seizure while at school, staff will do the following:

- Stay with student
- Protect student and provide privacy
- Note the time the seizure begins and ends
- Place barrier between self and body fluids
- Notify health office and contact parent/guardian
- Record seizure on observation form

911 will be called if ANY of the following occur: *(Notify office and parent when 911 is called)*

- Seizure lasts more than **three** minutes (unless otherwise indicated by health care provider).
- Student has difficulty breathing
- Student aspirates
- Student becomes injured during seizure or seizure occurs in the water
- Student has repeated seizures without regaining consciousness

PARENT / GUARDIAN AUTHORIZATION

1. I understand that this plan may be shared with all school staff working directly with my child.
2. I will contact the Licensed School Nurse/designee if a change in the current plan is indicated.
3. I authorize the Licensed School Nurse/designee and health care provider to exchange information related to my child's seizure plan and medication.
4. **I understand if my child rides the school bus and/or participates in before or after school activities, it is my responsibility to inform the staff/bus company of my child's seizure condition and health plan.**

Parent / Guardian Signature:_____**Date**: _____

LICENSED SCHOOL NURSE _____Date:_____