FARIBAULT PUBLIC SCHOOLS

SEIZURE HEALTH CARE PLAN

School Year: _____

Student's Name: _____ **D.O.B._____**

Emergency Contacts: (place in order of priority)

Name	**Relationship**	**Phone Number(s)**
1.		
2.		
3.		

Health Care Provider:_____ Phone:_____ Fax:_____

Hospital:_____ Phone:_____ City:_____

Type of Seizure Disorder:_____

Known Triggers:_____

Date of last known seizure:_____

Allergies:_____

Other Health Conditions:_____

Asthmatic ___Yes* ___No *High risk for severe reaction

USUAL SIGNS/SYMPTOMS (check all that apply)

___age of onset _____yrs.
___sensory or mental aura
___loss of consciousness
___falling down
___muscle rigidity (tonic phase)
___rhythmic convulsion(clonic)
___purposeless activity
___fluttering eyelids/blank stare
___twitching/jerking of body parts
___repetitive acts/movements
___confusion
___drowsy/sleepy post seizure
___headache post seizure
___hx of status epilepticus
___loss of awareness (e.g. unresponsiveness)
___loss of control (e.g. incontinence, drooling)
___decline in student's learning ability
___Average length of activity _____min
___Average frequency ____times per_____
___Other_____
_____

ACTION FOR SCHOOL PERSONNEL

1. Notify the health office **IMMEDIATELY** at **_____**.
2. Protect student from Injury:
    a. Assist student to the floor
    b. Put something soft under their head
    c. **DO NOT** restrain
    d. Monitor breathing
    e. **DO NOT** force anything into the student's mouth
    f. Remove nearby objects
    g. Remove tight clothing
    h. Comfort child afterwards

(PLEASE TURN OVER TO COMPLETE)

3. Document seizures
    a. Onset (time seizure started)
    b. Duration (how long the seizure lasted)
    c. Pattern of movement
    d. Body parts involved

4. Administer PRN medication as ordered.

5. **CALL "911"** if seizure lasts more than ____ minutes **and/or** you observe any of the following:

    - Blue/gray discoloration of fingernails or lips
    - Difficulty breathing
    - No pulse
    - Student has repeated seizures without regaining consciousness
    - Other_____

    a. Notify administration/office that 911 was called
    b. Notify paramedics of recorded seizure activity, start time, and any medication administered. A staff member will accompany the student to the hospital if the parent is not available.

6. Trained staff will begin CPR if needed

7. Notify parents

TO BE COMPLETED BY PRESCRIBING HEALTH PROFESSIONAL

I have prescribed the following medication to be administered for the reasons stated above during school hours:

Medication	Dose	Route	Frequency
Medication	Dose	Route	Frequency

Other medications the student is taking:_____

Does this student have any activity restrictions? ___NO ___YES (if yes please explain)_____

Comments:_____

_____

_____ _____ _____

Health Care Provider Signature **Phone #** **Date**

★ Parent/Guardian _____ Date _____

Health Office Nurse _____ Date _____

Health Coordinator _____ Date _____

Teacher _____ Date _____

FARIBAULT HEALTH OFFICE FAX NUMBERS

ALC	Fax: 507-333-6048	Faribault High School	Fax: 507-333-6111
Faribault Middle School	Fax: 507-333-6400	Jefferson Elementary	Fax: 507-333-6544
Lincoln Elementary	Fax: 507-333-6642	Roosevelt Elementary	Fax: 507-333-6734
McKinley/ All Early Childhood Programs	Fax: 507-333-6830		