District one91
Future Ready. Community Strong.

HEALTH PLAN

STUDENT: _____ **DOB:** _____ **GRADE:** _____

DIAGNOSIS/CONDITION: EPILEPSY

(Seizure type:_____)

Person to Contact	*Relationship*	*Work Phone*	*Home Phone*	*Cell Phone*

SEIZURE INFORMATION:

1. History _____
   _____
   _____
2. Last observed seizure (month and year) _____
3. Number of seizures in the past year _____
4. Warning signs _____
5. Length of typical seizure _____
6. Parts of body involved (Please describe) _____
7. Medical Alert bracelet/necklace: Yes _____ No _____
8. Other _____

MEDICATIONS

			SCHOOL	HOME
			(✓ below if experienced by your child)	
Name _____	Dose _____	Time _____	_____	_____
Name _____	Dose _____	Time _____	_____	_____
Name _____	Dose _____	Time _____	_____	_____

Allergies _____

TYPES OF LIMITATIONS

- Playground equipment Yes _____ No _____ N/A _____
- Swimming Yes _____ No _____ N/A _____
- Machinery operation Yes _____ No _____ N/A _____
- Other (please describe)
  _____

FIELD TRIP PLAN _____

_____

_____

Call 911 and parent if:

- seizure is longer than _____ minutes
- student has one seizure after another
- student is having difficulty breathing

Call parent if:

- student has a fever associated with seizure
- other _____

Notify office when 911 is called

FIRST AID FOR SEIZURES

1. Call the School Health Office at Ext. _____.
2. Gently protect the student from injury. Help them to lying position, preferably on their side, place something soft under their head, loosen tight clothing, and clear the area of hard or sharp objects.
3. DO NOT force any objects into the person's mouth.
4. DO NOT restrain movements.
5. DO NOT offer food or liquids until fully awake.
6. **Stay with student** until full recovery has occurred. Allow the student to rest if they need it.
7. Be reassuring and supportive when consciousness returns. Help reorient person.
8. Document the following:
   - What happened before, during, and after the seizure
   - Time seizure began and the length of the seizure
   - What parts of the body were involved and how

Health Care Provider _____ Clinic _____ Phone _____

Hospital of Choice _____

NURSING DIAGNOSIS	GOALS
1. Potential for physical injury	Prevent physical injury during a seizure
2. Potential for disturbance in self-concept and/or social isolation	Acceptance of self to be a whole person and age appropriate social interaction

		Plan Initiated	***Plan Reviewed/ Updated***
Parent/Guardian(s) Signature	_____	Date _____	Date _____
Licensed School Nurse	_____	Date _____	Date _____
Health Assistant	_____	Date _____	Date _____

Please contact the Licensed School Nurse if you have questions regarding this health plan or if you would like to meet to discuss other accommodations that may be needed.

***Co-curricular and Extra-curricular Activities**: If your child is involved in co-curricular / extra-curricular or other school sponsored activities or programs that take place during or outside of the school day, please contact the program coordinator, teacher, or coach to discuss accommodations that may be needed as it relates to your child's medical condition. Please provide needed emergency medications directly to the program coordinator, teacher, or coach.

I give permission for the Licensed School Nurse to consult (both verbally and in writing) with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the medical condition and/or medication(s)/treatment(s)/procedure(s) being used to treat the condition.

LSN signature_____ Date copy sent to Parent_____