Seizure Plan of Care

Form to be completed by Parents/Guardians and Child's Health Care Provider.

School Year _____

Student's Name _____ Date of Birth _____

Grade _____ Homeroom Teacher _____

Contact Information

Mother/Guardian _____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:

Name _____

Address _____

Telephone _____ Emergency Number _____

Other Emergency Contacts:

Name _____ Relationship _____

Telephone: Home _____ Work _____ Cell _____

Name _____ Relationship _____

Telephone: Home _____ Work _____ Cell _____

Please remember to let your child's school know of any changes to the contact information as soon as possible.

Notify parent in the following situations: _____

Seizure History

Seizure Type (please check all that apply)

Generalized: ☐ **Tonic Clonic** (grand mal) ☐ **Atonic** (drop attacks) ☐ **Myoclonic Absence** (petit mal)

Partial: ☐ **Simple** ☐ **Complex** (psychomotor/temporal lobe)

Other or Description of seizure _____

_____

How often do seizures occur: _____ How long does a typical seizure last: _____

Date of last seizure: _____

Warning signs (aura) or triggers if any, please explain: _____

_____

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List known triggers for your child's seizures _____

_____

Age when seizures were diagnosed: _____ Date of last exam for this condition: _____

Student's reaction to seizure _____

_____

☐ Yes ☐ No Does student need to leave the classroom after a seizure?

If yes, describe process for returning to classroom _____

_____

☐ Yes ☐ No Notify parent/guardian immediately for all seizure activity

Other instructions: _____

Any special considerations or safety precautions: _____

_____

♦ TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER ♦

Medications

Medication(s) given at home: _____

_____

Medication Allergies: _____

☐ Yes ☐ No Are any medications to be given during the school day?

Medication(s) to be administered during school hours by school personnel for control of seizures:

Prescriptions

Medication: _____

Dosage, Time, Route: _____

Duration: _____

Date of Prescription: _____

Possible Side effects: _____

Medication: _____

Dosage, Time, Route: _____

Duration: _____

Date of Prescription: _____

Possible Side effects: _____

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If seizure activity occurs, provide the following measures:

- ► Clear area of on lookers
- ► Ease student to floor **DO NOT** restrain or attempt to hold down
- ► Remove hazards in the area, such as sharp or hard objects (Desks, chairs, books, etc)
- ► Turn the student onto his/her side to maintain airway after a seizure
- ► **DO NOT** attempt to place any foreign object in mouth
- ► Have designated person contact Health Aide and/or parent/guardian
- ► Document seizure activity: Date, time, length of seizure
- ► Rest, re-orient, and offer assurance following seizure
- ► Other: _____

_____

☐ Administer Diastat® rectal gel for seizure lasting longer than _____ minutes. Dose _____

Other instructions for Diastat®: _____

☐ No Diastat® ordered

Call 911 for ANY of the following: (Please check all that apply)

☐ Seizure lasts more than _____ minutes.

☐ Anytime Diastat® is given

☐ Only if seizure does not stop within _____ minutes after giving Diastat®

☐ Two or more consecutive seizures occur

☐ Student is injured or has diabetes

☐ Student has difficulty breathing

☐ Other**:** _____

_____

I give permission to the school health aide or other designated staff members of _____ School to perform and carry out this Seizure Plan of Care established by our physician and myself. I also consent to the release of information contained in this medical management plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety. I give consent for school personnel to exchange information with my child's physician for the benefit of his/her health care.

Parent/Guardian Signature: _____ Date: _____

Physician/Prescriber Signature: _____ Date: _____

Physician/Prescriber PRINTED name: _____

Phone Number: _____ Fax Number: _____

Seizure Plan of Care

Seizure Type Descriptions	
Simple Partial	Remains conscious, twitching or numb sensation, usually lasting less than 30 seconds.
Complex Partial	Altered consciousness, transient staring, feelings of unreality and detachment. May have hallucinations, unexplained feelings of fear, disrupted memory, teething grinding, lip smacking, chewing, swallowing, scratching or pulling at buttons. Lasts usually no longer than 1-2 minutes.
Tonic-Clonic	Abrupt arrest of activity, loss of consciousness, symmetrical and rhythmical alterations of contraction and relaxation of major muscle groups. Ends suddenly in less than 5 minutes
Atonic	Abrupt loss of postural tone, loss of consciousness, confusion, lethargy and sleep. (May just fall asleep suddenly; when laughing, the child may fall down.)
Myoclonic	Brief random contractions of a muscle group, may occur on one side of the body, no loss of consciousness.
Absence	Very brief periods of altered awareness, eyelids may flutter or twitch, blank facial expression, lasts 5-10 seconds but can occur repeatedly.
Tonic	Lack of movement, stiffening of the entire body musculature, arms flex, legs, neck and head extend. Peculiar, piercing cry, cyanosis (bluish coloring to skin), may temporarily stop breathing, increased salivation.
Akinetic	No movement, but muscle tone is maintained. Like "freezing into position," may lose consciousness.