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 the form, sign, date, and return it to your child's school**.
   ___ NO **Do not fill out the remainder of this form, but sign,date, and return 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 the
"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: ________________ Phone#___________________
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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**:__________________