Hollidaysburg Area School District

SEIZURE CARE PLAN

Student's Name: _____ **Grade:** _____ **School Year:** _____

Goal #1: Student will remain seizure free at school/school activity during the current school year by following the prescribed seizure regimen and avoiding seizure triggers.
Goal #2: If a seizure does occur at school the student will remain safe and will not experience any further medical complications by following the outlined care plan.

In Case of emergency, contact:

1. _____ **Phone** _____ **Relationship:** _____
2. _____ **Phone** _____ **Relationship:** _____

Type of Seizure: _____

What does the seizure look like and how long does it usually last? _____

_____

Seizure Triggers: _____

Are medications taken to control the seizures? No _____ **Yes** _____ **(List below)**

Medications:

1. _____ **Dosage:** _____ **Time:** _____
2. _____ **Dosage:** _____ **Time:** _____
3. _____ **Dosage:** _____ **Time:** _____

Does the student require any medication at school for seizures: No _____ **Yes** _____
****If medication required, the physician must complete the attached medication form for school *****

The following steps will be followed if a seizure occurs at school:

1. **Position the student for safety**
2. **Time the seizure**
3. **Clear the area of other students or safety hazards**
4. **Notify the parent/guardian**
5. **Call 911 if the seizure meets emergency criteria**
6. **Allow the student to rest**
7. **Send the student home or for further medical care if necessary**

Other Instructions from Parent/Guardian:

_____

_____

Parent Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

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