**Jefferson City Schools - Student Health Services**

**Seizure** Health Management Plan

School Year:_____

| | |
|---|---|
| **Student Name:** | **DOB:** **Age:** |
| **School:** | **Teacher:** |
| **Mother:** | **Father:** |
| **Home:** | **Home:** |
| **Work:** | **Work:** |
| **Cell:** | **Cell:** |
| **Hospital Preferences:** | |

**SEIZURE Type:**_____ **Length:**_____ **Frequency:**_____**Date of last seizure:**_____

**Description of seizure(s):**_____

**Seizure triggers/warning signs:**_____

**Emergency anti-seizure medication ever used:**_____ **Most recent date administered:**_____

**Student History (including other medical conditions):**

**Medications (include name, dose, frequency):**

**EMERGENCY MEDICATION:**

| Green Zone (< 2minutes) | Yellow Zone (2-5 Minutes) | Red Zone (More than 5 minutes or 3 or more seizures in an hour) |
|---|---|---|
| **Basic Seizure First Aid**<br>● Record seizure activity **(START TIMING)**<br>● Contact parent<br>● Do not restrain<br>● Protect head from injury<br>● Do not put anything in mouth<br>● Stay with child until fully conscious<br>● Monitor breathing | ● Continue seizure first aid<br>● Call for help<br>● Prepare to administer Diastat/Versed<br>● Notify parent/guardian<br>● Student may return to class/home as instructed by parent/guardian | ● Administer anti-seizure medication as prescribed<br>● Monitor respirations and heart rate<br>● Call 911 if seizure:<br>○ Is greater than 7 minutes<br>○ Injury has occured<br>○ Breathing does not return to normal |

**Special considerations/parent requests:**

*School Clinic: Copy of plan to be provided to Transportation Supervisor.* Information about students and family is strictly confidential.

_____ _____

Parent Signature/Date School Clinic Signature/Date

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Provider Signature/Date