long beach unified school district

Office of School Support Services
Coordinated School Services
STUDENT HEALTH SERVICES
2221 Argonne Ave., Long Beach, CA 90815
Telephone: (562) 986-6870 ext. 248 Fax: (562) 494-8952

INDIVIDUALIZED HEALTH AND SUPPORT PLAN (EPILEPSY/SEIZURE DISORDER)

Student's name _____ **Birthdate** _____ **Grade** _____

Parent's name _____ **Home phone**_____ **Cell phone** _____

Emergency contact # 1: _____ **Phone:** _____**Relationship to student:** _____

Emergency contact #2: _____ **Phone:**_____ **Relationship to student:** _____

USUAL TREATMENT (as indicated by physician and parent):
☐ Medication(s) given at home are _____
☐ Other _____

TYPE (S) OF SEIZURE THIS STUDENT HAS:
☐ Generalized – Grand Mal (body falls, stiffens and jerks, eyes roll back, may be incontinent of urine/stool, foaming or drooling at mouth)
☐ Generalized – Absence/Petit Mal (staring spells, eyes blink, "daydreaming")
☐ Partial (purposeless activity, confused, fidgets with clothing, smacks lips, jerking of one limb or side of body)
☐ Other _____

SIGNS OF EMERGENCY – CALL 911 – PARAMEDICS if:
☐ seizure lasts longer than _____ minutes ☐ more than one seizure occurs
☐ seizure is associated with illness, injury, or high temperature

ACTIONS FOR TEACHER AND/OR OTHER SCHOOL PERSONNEL:
REMEMBER YOU CANNOT STOP A SEIZURE – IT MUST RUN ITS COURSE
☐ do not put anything in student's mouth ☐ do not try to restrain
☐ gently assist the student to the floor ☐ push nearby objects away from student to prevent injury
☐ turn student on side and tilt chin back to open airway (this prevents student from choking on excess saliva and /or vomitus which may occur during seizure)
☐ when possible, place soft object (pillow, jacket, etc.) under student's head to protect from injury
☐ notify the nurse (if she's on site) and parent (nurse will notify parent if she's on site at the time of the seizure)
☐ administer prescribed medication rectally_____
☐ Other _____
DO NOT GIVE STUDENT ANYTHING BY MOUTH UNTIL STUDENT IS FULLY AWAKE AND ALERT

Additional information or comments _____

Effective date of individualized Health and Support Plan: _____
PARENT AGREEMENT: I agree with the Individualized Health and Support Plan.

Parent/guardian signature _____ Date _____
Physician signature _____ Date _____
School nurse signature _____ Date _____