THOMPSON SCHOOL DISTRICT

Health Services Department

ID photo

Seizure Disorder Individualized Health Service Plan

STUDENT: **Birth Date:** **School:** **Grade:**

Goal: To decrease or eliminate the impact of the student's disease condition on access to education. To prevent injury, aspiration and damage to self image due to seizure activity.
Objectives: Seizure activity will be recognized early, treated appropriately and student will return promptly to educational setting.

Emergency contacts (in the order you want them contacted – please update regularly):

Name	Relationship	Phone Numbers

Physician currently treating child's seizure disorder:

Physician's phone number:

The Health Office staff has your permission to contact the physician listed above: ❑ yes ❑ no

List **any medications** taken **routinely** by your child:

Name	Amount	Time Given

List any known **medication allergies** your child has:

Please mark the type of seizure disorder your child has:

❑Generalized tonic-clonic ❑Absence ❑Simple Partial ❑Complex Partial
❑Atonic ❑Rolandic

Approximately how often does your child have a seizure?

❑ daily ❑ weekly ❑ monthly ❑ yearly ❑ less than once a year

What was the date of your child's last seizure?

Does your child experience an aura? ❑ Yes ❑ No
If so, please mark the **characteristics of the aura**:

- ❑ Brief sensation in the stomach or head such as a sinking or rising feeling.
- ❑ Buzzing sound
- ❑ Unpleasant odor
- ❑ Spots before eyes
- ❑ Feeling of numbness
- ❑ Other:_____

Please mark the **characteristics** your child has during a seizure:

- ❑ Tonic/clonic muscle movements
- ❑ Loss of consciousness
- ❑ Rapid, labored breathing
- ❑ Staring
- ❑ Eye blinking
- ❑ Incontinence of urine or bowel
- ❑ Verbal noises
- ❑ Continued movement of one part of the body
- ❑ Lip smacking
- ❑ Facial twitching
- ❑ Sudden loss of postural tone and consciousness ("drop attacks")
- ❑ Other:_____

School Personnel will treat <u>Grand Mal Seizures</u> in the following manner:

1. If the student is having tonic/clonic movements, provide protection during seizure activity. Help the student to the floor in a position lying on his/her side to prevent aspiration. Clear nearby furniture away from the student's reach. Do not restrain the student's flailing movements. Provide protection for the student's head.
2. Do not place anything in the student's mouth. Clear secretions from around mouth if necessary.
3. Loosen any tight clothing around the neck.
4. Observe for possible injury, respiratory distress, skin color and vital signs (as possible).
5. Document seizure activity (date, time, duration, objective facts about seizure behavior).
6. Explain to the class members that the seizure will pass, encourage them to go back to their activities and not to stare. Explain that a seizure disorder is a disease and that understanding and acceptance will be helpful and comforting to the student.
7. Allow student to rest comfortably after the seizure until he/she is oriented.
8. Provide the opportunity and assistance it needed for the student to change clothing and clean up as needed for incontinence.
9. Examine the student for injury sustained as a result of the seizure and treat appropriately.
10. Debrief with class members that saw the seizure, if needed, and encourage their support.
11. Allow the student to return to class activities when fully oriented if there are no contraindications.

School Personnel will treat <u>all other seizure activity</u> in the following manner:

1. Observe for possible injury, respiratory distress, skin color and vital signs (as possible).
2. Document seizure activity (date, time, duration, objective facts about seizure behavior).
3. Allow the student to return to class activities when fully oriented if there are no contraindications
4. Seek emergency medical assistance (call 911) and notify parent immediately should seizure activity last longer than _____ minutes or should another seizure of this type occur within a short period of time.

School Personnel will CALL 911 if the student has any of the following:

- Focal or absence seizure activity lasts longer than _____ minutes.
- Student has head injury or other serious injury during the seizure.
- Student stops breathing or has breathing difficulty.

I give permission for the information contained on this Individualized Health Service Plan to be shared with adults in the school setting that will be working with my child.

This Individualized Health Service Plan will remain in effect for 1 year or until the health status or physician's orders change.

It is the responsibility of the parent to notify the school nurse whenever there is any change in the student's health status or care.

Date: **Signature of parent or guardian:**

Date: **Signature of school nurse:**

Date: **Signature of physician (if required):**