SEIZURE DISORDER EMERGENCY HEALTH PLAN

Student_____ DOB_____
School _____Grade_____
Teacher_____School Year ___-__

Contact:

Parent/Guardian_____H#_____W#_____C#_____
Parent/Guardian_____H#_____W#_____C#_____
Parent/Guardian_____H#_____W#_____C#_____
Physician_____ Phone #_____
Hospital of choice:_____

Medications

Name_____Dose_____Time_____Home___ School___
Name_____Dose_____Time_____Home___ School___
Name_____Dose_____Time_____Home___ School___

Allergies_____

Seizure Information

1. Last observed seizure (month & year):_____
2. Number of seizures in the past year: _____
3. Warning signs:_____
4. Length of typical seizure:_____
5. Parts of body involved:_____

Activity Limitations:_____
Field Trip Plan:_____

Emergency Plan of Care:

Protect student from injury by moving nearby hard/sharp objects away.
Help him/her to a lying position and place something soft under head, loosen tight clothing.
Stay with the student until fully alert.
DO NOT: hold the person down
DO NOT: put anything in the person's mouth
DO NOT: give the person water, pills, or food until fully alert.
Call 911 and parent if:

- Seizure is longer than _____minutes
- Student has one seizure after another
- Student is having difficulty breathing

Parent/Guardian:_____Date:_____
School Nurse:_____Date:_____

We ask you to complete this form at the beginning of every school year to ensure that we have the most current information on your child. The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's health and safety. Please contact your school promptly with any changes of information on this form.

Seizure Disorder Training

Student Name_____Grade_____
School Nurse_____
Date_____

I have been instructed on this student's Emergency Health Plan and have been given a copy of the Emergency Health Plan for this student. I have been given an opportunity to ask questions and clarify concerns. I understand that should a question or concern arise in the future, I should contact the school nurse.

Printed Name	Signature	Position	Date