MANKATO AREA PUBLIC SCHOOLS
COMMUNITY EDUCATION
ACES

INDIVIDUAL HEALTH PLAN/EMERGENCY CARE PLAN FOR CHILD WITH SEIZURES

Child's Name: ____ Birth Date: _______________

Program Name/Site: ____ Grade: __________________

* *

1. **My child has seizures.**
   ☐ **YES** **Complete form, sign, date, and return it to the CE Program your child attends.**

   ☐ **NO** **Parent/Guardian Signature:** ______________________________ **Date:** _____________
   (If "NO" is checked, do not fill out the remainder of the form, just sign, and return it)

2. Check the type of seizure your child has:
   - ☐ Generalized tonic-clonic: Muscles become rigid with convulsive movements and impaired consciousness
   - ☐ Complex partial (focal impaired awareness): May consist of purposeless activity, not aware of what is happening
   - ☐ Simple partial (focal aware): Jerking of one limb or side of body, consciousness maintained
   - ☐ Absence: Brief interruption of consciousness often characterized by an appearance of daydreaming
3. **List any known seizure triggers:** ____
4. Describe any warnings and/or behavior changes before the seizure:

   ____

5. Any recent changes in your child's seizure patterns: ❑ **YES** ❑ **NO**

   If yes, explain: ____

6. Describe what happens *during* the seizure:

   ____

7. Describe what happens *after* the seizure:

   ____

8. How long does seizure last? ____

9. Approximate date of last seizure: ____________________

10. How frequent are seizures? ❑ daily ❑ weekly ❑ monthly ❑ yearly

11. Medication your child takes at home for seizures: ____

12. Will your child need any treatment or medication during CE program for seizures: ❑ **YES** ❑ **NO**
    If yes, explain: ____

If medication is needed at the program, complete the Consent Form for Administration of Medication

OVER

13. Are there any special considerations or precautions regarding program activities and field trips?

❑ **YES** ❑ **NO**

If yes, explain: _____

14. HEALTH CARE PROVIDER NAME: _____ PHONE: _____

CLINIC: _____ FAX: _____

Emergency Contacts: (*list in order of who to call first*)

Name: _____ Relationship: _____ Phone: _____

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CE ACTION/EMERGENCY PLAN

If student has a seizure during the CE program, staff will do the following:

- Stay with child
- Protect child and provide privacy
- Note the time the seizure begins and ends
- Give emergency seizure medication if ordered by provider
- Notify program supervisor and contact parent/guardian

911 will be called if ANY of the following occur: *(notify program supervisor and parent when 911 is called)*

- Seizure lasts more than **three** minutes (unless otherwise indicated by the health care provider).
- Child has difficulty breathing after seizure has ended
- Child aspirates
- Child becomes injured during seizure or seizure occurs in the water
- Child has repeated seizures without regaining consciousness

PARENT/GUARDIAN AUTHORIZATION

1. I understand that this plan may be shared with all CE staff working directly with my child.
2. I will contact the CE program coordinator/supervisor if a change in the current plan is indicated.
3. I authorize the CE program coordinator/designee and health care provider to exchange information related to my child's seizure plan and medication.

Parent/Guardian Signature: **Date:**