

Student: \_\_\_\_\_

Grade: \_\_\_\_ DOB: \_\_\_\_\_ School Year: \_\_\_\_\_

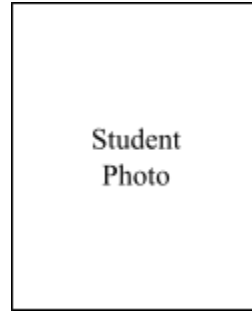
Mother: \_\_\_\_\_

Best phone number: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Best phone number: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_



## Seizure Information

Seizure Type/Name: \_\_\_\_\_ How Often: \_\_\_\_\_

What Happens: \_\_\_\_\_ How Long Does It Lasts: \_\_\_\_\_

### SEIZURE TRIGGERS (check all that apply):

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Missed Medicine              | <input type="checkbox"/> Emotional Stress | <input type="checkbox"/> Menstrual Cycle      | <input type="checkbox"/> Missing meals           |
| <input type="checkbox"/> Lack of Sleep                | <input type="checkbox"/> Physical Stress  | <input type="checkbox"/> Flashing Lights      | <input type="checkbox"/> Illness with high fever |
| <input type="checkbox"/> Specific food Specify: _____ |   | <input type="checkbox"/> Other Specify: _____ |  |

### SYMPTOMS that signal an oncoming seizure (check all that apply):

- |  |   |   |                                    |  |
|--|---|---|------------------------------------|--|
| <input type="checkbox"/> Headache                          | <input type="checkbox"/> Staring Spells | <input type="checkbox"/> Confusion            | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Change in Vision/Aura |
| <input type="checkbox"/> Sudden Feeling of Fear or Anxiety |   | <input type="checkbox"/> Other Specify: _____ |                                    |  |

**Does the student need to leave the classroom after a seizure?**  Yes  No

If yes, describe process for returning student to classroom: \_\_\_\_\_

### POST SEIZURE RECOVERY typical behaviors after seizure (check all that apply):

- |  |   |   |                                     |  |
|--|---|---|-------------------------------------|--|
| <input type="checkbox"/> Headache      | <input type="checkbox"/> Drowsiness/Sleep | <input type="checkbox"/> Nausea               | <input type="checkbox"/> Aggression | <input type="checkbox"/> Confusion/Wandering |
| <input type="checkbox"/> Blank Staring |   | <input type="checkbox"/> Other Specify: _____ |                                     |  |

## Seizure Medicine *(To be Completed by a Recognized Medical Authority\*)*

Name of Medication	Dosage Prescribed	Administration Time/Frequency

*\* Physician, Physician Assistant, or Nurse Practitioner licensed to practice in the State of California*

Date: \_\_\_\_\_

Print Physician's Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office  
Stamp

*This plan is in effect for only one school year.*

All Emergency Care Plans need to be updated annually. The information given assists the district nurse in developing an Individual Healthcare Plan for each student.

1. **Medical alert jewelry worn:**  Yes  No    **IEP:**  Yes  No    **504 Plan:**  Yes  No
2. **Age at onset of seizures?** \_\_\_\_\_ **When was the student's last seizure?** \_\_\_\_\_
3. **Describe what a seizure looks like** (stares into space, body stiffens, loses bladder control, etc.):  
 \_\_\_\_\_  
 \_\_\_\_\_
4. **Has the student ever had a seizure that lasted longer than 5 minutes?**  Yes  No
5. **Describe the student's understanding of their seizure disorder**  
 None                       Limited                       Basic                       Knowledgeable
6. **Special considerations and precautions** (check all that apply and describe any actions that should be taken):  
 General health \_\_\_\_\_  
 P.E. & sports \_\_\_\_\_  
 Learning \_\_\_\_\_  
 Recess \_\_\_\_\_

## SEIZURE FIRST AID



Image adapted with permission from the Epilepsy Foundation of America

Basic Seizure First Aid	A seizure is generally considered an emergency when:
Stay calm & track time Keep child safe Do not restrain Do not put anything in mouth Stay with child until fully conscious Record seizure in log <b>For chronic seizure:</b> Protect head Keep airway open/watch breathing Turn child on side	Convulsive seizure lasts longer than 5 minutes Student has repeated seizures without regaining consciousness Student is injured or has diabetes Student has a seizure for the first time Student has breathing difficulties Student has a seizure in water