EMERGENCY CARE PLAN – SEIZURE DISORDER

Student Name _____Birthdate_____Grade/Teacher_____

School Name_____ School Year_____

My child's seizure disorder includes: Check all that apply and fill in blanks.

MY CHILD'S TYPE OF SEIZURE AND BEHAVIOR	EMERGENCY CARE AT SCHOOL
□**Tonic/Clonic Seizure (Grand Mal)** □ Loss of consciousness □ Tremors □ Aura(warning)_____ □ Muscle jerks □ Sudden cry □ Saliva on lips □ Bluish skin color □ Possible loss of bladder or bowel control □ Becoming rigid □ Usually lasts _____minutes □ Confusion, muscle limpness and drowsiness after the seizure followed by full return of consciousness in _____minutes □ Other seizure behavior:_____ _____	• Assist student to the floor, turn on side • TIME THE SEIZURE • Protect head from injury – place something soft under head • Call office _____. • Clear hazards (furniture or other objects) • Prevent injuries and treat any that occur • Have another adult direct students away from area • Do not attempt to put anything in their mouth or try to restrain in any way • Administer emergency medication: □ Yes □ No If Yes: Name of medication_____ Instructions_____ • Contact parents immediately □ Other: _____ • **Call 911 if one or more:** • Single seizure lasts longer than 5 minutes • If multiple seizures occur • Student appears injured • Fails to regain consciousness after the seizure • Emergency medication is given • No pulse and/or breathing–**Start CPR immediately** □ Other: _____
□**Partial, Absence or Unclassified Seizure** □ Performs aimless activities □ Chewing □ Fumbling □ Wandering □ Shaking □ Confused speech □ Twitching of mouth or hands □ Brief staring spell □ Usually lasts _____ minutes □ Consciousness is affected □ Other seizure behavior: _____ _____	• Do not hold down or grab • Protect from hazards and injuries • Time the seizure • Stay with student, speak gently and help student get back on task following seizure • Allow _____ minutes to rest and re-orient self before returning to class □ Report to parents: □ daily □ weekly □ immediately □ Other: _____ • **Call 911 if one or more:** • Full awareness does not return • Student appears injured • No pulse and/or breathing–**Start CPR immediately** □ Other: _____

If your child requires medication at school, you must have a **Prescription Medication Permission Form** signed by doctor and parent on file **BEFORE** the medication can be given.

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INDIVIDUALIZED HEALTH CARE PLAN – SEIZURE DISORDER CONTINUED

Student Name _____

1. At what age did your child have their first seizure?_____
2. How often do the seizures occur? _____ Date of last seizure_____
3. Has your child ever had a seizure lasting longer than five minutes? □ Yes □ No
    a. If yes, what needs to be done _____
4. What events might cause a seizure (such as fever, blinking lights, etc.)?_____

    _____
5. What safety precautions or activity restrictions are needed at school? _____

    _____
6. What is the date of your child's last medical evaluation for seizures?_____
7. Does your child take medication to control their seizures? □ Yes □ No
    a. If yes, name of medication(s) and dose_____
    b. Time(s) of day medication(s) are taken_____
8. What additional information will help school staff understand your child's seizure disorder plan?

    □ Physical Education/Recess precautions_____

    _____

    □ Transportation to and from school _____

    _____

    □ Other concerns_____

    _____

    _____

    _____

We recommend that students with a seizure disorder wear a Medic-Alert bracelet/pendant at all times.

School Nurse Signature_____Date Reviewed_____

Updated 1/7/2015