

Warren Township High School

Almond Campus
847-548-6899
Fax: 847-548-7171

O'Plaine Campus
847-599-4766
Fax: 847-599-4679

Seizure Management Plan

TO BE COMPLETED BY PARENT(S):

Date: _____

Student	Grade	Teacher
Mother's Name & Day Time Phone	Father's Name & Day Time Phone	
Physician treating condition	Address	
	Physician Phone	Fax

TYPE(S) OF SEIZURE: _____

DESCRIPTION OF TYPICAL SEIZURE

Body involvement: _____

Average Duration: _____

Frequency (daily, weekly, other): _____

Usual times of day: _____

Behavior/warning prior to seizure: _____

Student response to seizure: _____

Care needed during seizure, aside from typical precautions: _____

Care needed after seizure:

☐

Rest in nurse's office

☐

Other: _____

Daily Medication

MEDICATION	DOSE/ROUTE	TIME	POSSIBLE SIDE EFFECTS

Physical Education/Team Sports:☐
☐

Full participation, no limitations

Participation with the following modifications: _____
_____**Emergency Intervention:**☐
☐
☐
☐If seizure lasts longer than _____ minutes, then _____ (Medication/dosage)

If _____ or more seizures occur in a row, then _____

If seizure occurs on the bus, then _____

Other: _____

Instructions:☐Seizure Observation record (as needed) to be completed by staff during school and shared with parents on a _____ interval.
(Weekly/Monthly)☐

If school is unable to reach parents in an emergency, permission is granted to contact physician listed above.

☐

I/We agree to release this information to the following staff, with the expectation that confidentiality will be respected at all times:

☐ Nurse☐ After school caregivers/coaches☐ Teachers☐ Bus Personnel☐ LST (counselor, social worker)☐ Other: _____**Additional Comments:** _____

Parent(s) Signature_____
Date_____
Physician(s) Signature_____
Date

Return this form to:

**Warren Township High School
Nurse's Office**