HUSD STUDENT SEIZURE CARE PLAN

School Year: _____

Student's Name: _____ DOB: _____

Parent/Guardian: _____ Phone: _____ Cell: _____

Parent/Guardian: _____ Phone: _____ Cell: _____

Emergency Contact: _____ Phone: _____ Cell: _____

Treating Physician: _____ Phone: _____ Fax: _____

Significant Medical History: _____

Seizure Information

Seizure Type **Length** **Frequency** **Description**

_____

Has your child ever been hospitalized because of seizures? ☐ Yes ☐ No

If yes, please provide details regarding dates, duration of stay, and treatment received:

_____

Any risk factors for seizures: Birth Injury ☐ Yes ☐ No Head Injury ☐ Yes ☐ No Febrile Seizure ☐ Yes ☐ No

Stroke ☐ Yes ☐ No Prior Neurosurgery ☐ Yes ☐ No

If you answered yes to any of the above risk factors, please explain:

_____

Date of First Seizure: _____ Date of last Seizure: _____ How often do Seizures occur: _____

Seizure triggers or warning signs: _____

Student's response after a seizure: _____

How would you rate your CHILD's level of understanding regarding their seizures and treatment plan? Knowing what things could trigger a seizure _____ Minimal ☐ Some ☐ Good ☐

Avoiding activities that put them at risk for injury should a seizure occur _____ Minimal ☐ Some ☐ Good ☐

Comfort level/ability to tell an adult when experiencing symptoms of seizure activity _____ Minimal ☐ Some ☐ Good ☐

Student's response after a seizure: _____

Comfort Measures

Please describe comfort you provide during or after a seizure:

_____

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions: _____

If child has a seizure at school, follow basic first aide for seizure, and rescue therapy as indicated in Seizure Action Plan.

Physician Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

HUSD STUDENT SEIZURE CARE PLAN

BUS PLAN FOR SEIZURES

School Year: _____ AM: _____/PM: _____ Bus Route

Student's Name: _____ DOB: _____

School / Program: _____ Teacher: _____

Directions for Assisting Student on School Bus: Seizure

If a seizure occurs:

- Look at the clock; write down when the seizure starts and stops. Keep Calm, Reassure Other Children.
- While protecting student's head – slowly move student to a safe lying position on floor or in seat.
- Clear the area around student of anything that could hurt/harm the child.
- Stay with student and provide comfort during the seizure(s).
- May need to turn student's head to one side to keep airway clear & prevent choking.
- **DO NOT** restrain any movements – **DO NOT** put anything into student's mouth during seizure.
- If seizures are continuous or breathing stops - **CALL 911 – Start CPR if necessary!**

Emergency Contact Name: _____

Phone Numbers: Home: _____ Cell: _____

Work: _____Other: _____

Health Aide Signature: _____ Date: _____ Phone #: _____

Parent Signature: _____Date: _____

HEALTH AIDE: EMAIL THIS FORM TO HUSD TRANSPORTATION

SEIZURE ACTION PLAN (SAP)

EPILEPSY FOUNDATION | END EPILEPSY

Name: _____ Birth Date: _____

Address: _____ Phone: _____

Parent/Guardian: _____ Phone: _____

Emergency Contact/Relationship _____ Phone: _____

Seizure Information

Seizure Type	How Long It Lasts	How Often	What Happens

Protocol for seizure during school (check all that apply) ☑

- ☐ First aid – **Stay. Safe. Side.**
- ☐ Give rescue therapy according to SAP
- ☐ Notify parent/emergency contact
- ☐ Contact school nurse at _____
- ☐ Call 911 for transport to _____
- ☐ Other _____

First aid for any seizure

- ☐ **STAY** calm, keep calm, **begin timing seizure**
- ☐ Keep me **SAFE** – remove harmful objects, don't restrain, protect head
- ☐ **SIDE** – turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe magnet for VNS
- ☐ Write down what happens _____
- ☐ Other _____

When to call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

When **rescue therapy** may be needed:

WHEN AND WHAT TO DO

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

If seizure (cluster, # or length) _____

Name of Med/Rx _____ How much to give (dose) _____

How to give _____

Care after seizure

What type of help is needed? (describe) _____

When is student able to resume usual activity? _____

Special instructions

First Responders: _____

_____

Emergency Department: _____

_____

Daily seizure medicine

Medicine Name	Total Daily Amount	Amount of Tab/Liquid	How Taken (time of each dose and how much)

Other information

Triggers: _____

Important Medical History _____

Allergies _____

Epilepsy Surgery (type, date, side effects) _____

Device: ☐ VNS ☐ RNS ☐ DBS Date Implanted _____

Diet Therapy ☐ Ketogenic ☐ Low Glycemic ☐ Modified Atkins ☐ Other (describe) _____

Special Instructions: _____

_____

Health care contacts

Epilepsy Provider: _____ Phone: _____

Primary Care: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Pharmacy: _____ Phone: _____

My signature _____ Date _____

Provider signature _____ Date _____

Epilepsy.com

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