

Date plan created: _____ Date plan revised: _____

NAME:		Birthdate:		Teacher:	
Grade:	School:	☐ Bus #	☐ Walk	☐ Drive	
Doctor:	Phone:	Fax:	Preferred Hospital:		

History (including current medication): _____

TYPES of SEIZURES	
Tonic Clonic	Absence
Muscles tense, body rigid, followed by a temporary loss of consciousness and violent shaking of entire body. Comments:	Staring spells. May drop an object s(he) is holding or may stumble momentarily. Comments:
	Psychomotor Some degree of impairment of consciousness, may or may not be accompanied by automatic movements like lip smacking, roaming, and non-goal oriented activity. Comments:
IF YOU SEE THIS	DO THIS Adult stays with student at all times
ABSENCE AND PYSCHOMOTOR SEIZURES:	Time seizure and monitor student closely. Notify the nurse _____ and parent _____. Gently support and protect student from harm. Do not restrain. No first aid is needed if no injury. After seizure, calmly reorient student to his surroundings. Record seizure activity on Seizure Observation Log.
TONIC CLONIC SEIZURE ACTIVITY <u>Do not hold student down. Do not put anything in their mouth.</u> (for loss of bowel/bladder cover with blanket for privacy)	Time Seizure Activity. After seizure record events on the Seizure Observation Log. Stay calm & ease student to floor to avoid a fall. Clear area around student-move hard objects. Keep others away. Support student on his left side to allow vomit/drool to drain. Loosen clothing around neck. Place soft material under head. NOTIFY THE NURSE _____ & PARENT _____.
CALL 911 IF:	
- Seizure does not stop by itself or is first tonic clonic seizure - Seizure does not stop within _____ minutes - Child does not start waking up within _____ minutes after seizure is over	- Another seizure starts immediately after the first seizure - Bluish color to lips AFTER seizure ends - Prolonged loss of consciousness - Stops breathing (START RESCUE BREATHING/CPR)
➤ NO MEDICATION ORDERED FOR STUDENT.	
Document seizure activity on Seizure Observation Log (attached).	

LHP Signature	Date	Telephone:
		Fax Number:
LHP Printed Name	Start Date:	End Date:

PARENT/GUARDIAN SECTION

EMERGENCY CONTACTS

Name
Home Phone
Work Phone
Other

Name
Home Phone
Work Phone
Other

ADDITIONAL EMERGENCY CONTACTS:

1.	Relationship:	Phone:
2.	Relationship:	Phone:

****Does the student need classroom, school activity, or recess accommodations? ____yes____no. If yes, specify_____**

- A new health care plan for seizures must be submitted each school year.
- I understand that if any changes are needed on the HCP, it is the parent's responsibility to contact the school nurse.
- It is the parent's responsibility to alert all other non-school programs of their child's health condition.
- Medical information may be shared with school staff working with your child and 911 staff, if they are called.
- I have reviewed the information on this health care plan and medication order and request/authorize trained school employees to provide this care and in accordance with the Licensed Healthcare Provider's (LHP's) instructions.
- I understand this is a life-threatening plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child's seizure disorder between the LHP office and the school nurse.
- *My signature below shows I have reviewed and agree with this health care plan.*

Parent/Guardian Signature

Date

EXPECTED POST-SEIZURE BEHAVIOR

- ◆ Tiredness
- ◆ Weakness
- ◆ Sleeping, difficult to arouse
- ◆ May be somewhat confused

- ◆ Regular breathing
- ◆ Can last a few minutes or hours
- ◆ May be somewhat confused

For District Nurse's Use Only

This plan has been reviewed/approved by the School District Nurse.

Medication/Device(s)

Expiration date(s):

School Nurse Signature

Date

Phone:

Health care plan and medication (if prescribed) must accompany student on any field trip or school activity.

****Keep plan readily available for substitutes.****

SEIZURE OBSERVATION LOG

Date & Time				
Seizure Length				
Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)				
Conscious (yes/no/altered)				
Injuries (briefly describe)				
Muscle tone/body movements	Rigid/clenching			
	Limp			
	Fell down			
	Rocking			
	Wandering around			
	Whole body jerking			
Extremity movements	(R) arm jerking			
	(L) arm jerking			
	(R) leg jerking			
	(L) leg jerking			
	Random Movement			
Color	Bluish			
	Pale			
	Flushed			
Eyes	Pupils dilated			
	Turned (R or L)			
	Rolled up			
	Staring or blinking (clarify)			
	Closed			
Mouth	Salivating			
	Chewing			
	Lip smacking			
Verbal Sounds (gagging, talking, throat clearing, etc.)				
Breathing (normal, labored, stopped, noisy, etc.)				
Incontinent (urine or feces)				
Post-seizure observation	Confused			
	Sleepy/tired			
	Headache			
	Speech slurring			
	Other			
Length to Orientation				
Parents Notified? (time of call)				
9-1-1 Called? (call time & arrival time)				
Observer's Name				

Questionnaire for Parent of a Student with Seizures

Please complete all questions. This information is essential for the school nurse and school staff in determining your child's special needs and providing a positive and supportive learning environment. If you have any questions about how to complete this form, please contact your child's school nurse.

Contact Information

Student's Name	School Year	Date of Birth	
School	Grade	Classroom	
Parent/Guardian	Phone	Work	Cell
Parent/Guardian Email			
Other Emergency Contact	Phone	Work	Cell
Child's Neurologist	Phone	Location	
Child's Primary Care Doctor	Phone	Location	
Significant Medical History or Conditions			

Seizure Information

1. When was your child diagnosed with seizures or epilepsy? _____

2. Seizure type(s)

Seizure Type	Length	Frequency	Description

3. What might trigger a seizure in your child? _____

4. Are there any warnings and/or behavior changes before the seizure occurs? ☐ YES ☐ NO
If YES, please explain: _____

5. When was your child's last seizure? _____

6. Has there been any recent change in your child's seizure patterns? ☐ YES ☐ NO
If YES, please explain: _____

7. How does your child react after a seizure is over? _____

8. How do other illnesses affect your child's seizure control? _____

Basic First Aid: Care & Comfort

9. What basic first aid procedures should be taken when your child has a seizure in school?

10. Will your child need to leave the classroom after a seizure? ☐ YES ☐ NO
If YES, what process would you recommend for returning your child to classroom: _____

Basic Seizure First Aid

- 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
- For tonic-clonic seizure:**
- Protect head
 - Keep airway open/watch breathing
 - Turn child on side

Seizure Emergencies

11. Please describe what constitutes an emergency for your child? (Answer may require consultation with treating physician and school nurse.)

12. Has child ever been hospitalized for continuous seizures? ☐ YES ☐ NO

If YES, please explain:

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Seizure Medication and Treatment Information

13. What medication(s) does your child take?

Medication	Date Started	Dosage	Frequency and Time of Day Taken	Possible Side Effects

14. What emergency/rescue medications are prescribed for your child?

Medication	Dosage	Administration Instructions (timing* & method**)	What to Do After Administration

* After 2nd or 3rd seizure, for cluster of seizure, etc.

** Orally, under tongue, rectally, etc.

15. What medication(s) will your child need to take during school hours? _____

16. Should any of these medications be administered in a special way? ☐ YES ☐ NO

If YES, please explain: _____

17. Should any particular reaction be watched for? ☐ YES ☐ NO

If YES, please explain: _____

18. What should be done when your child misses a dose? _____

19. Should the school have backup medication available to give your child for missed dose? ☐ YES ☐ NO

20. Do you wish to be called before backup medication is given for a missed dose? ☐ YES ☐ NO

21. Does your child have a Vagus Nerve Stimulator? ☐ YES ☐ NO

If YES, please describe instructions for appropriate magnet use:

Special Considerations & Precautions

22. Check all that apply and describe any consideration or precautions that should be taken:

- | | |
|---|--|
| ☐ General health _____ | ☐ Physical education (gym/sports) _____ |
| ☐ Physical functioning _____ | ☐ Recess _____ |
| ☐ Learning _____ | ☐ Field trips _____ |
| ☐ Behavior _____ | ☐ Bus transportation _____ |
| ☐ Mood/coping _____ | ☐ Other _____ |

General Communication Issues

23. What is the best way for us to communicate with you about your child's seizure(s)? _____

24. Can this information be shared with classroom teacher(s) and other appropriate school personnel? ☐ YES ☐ NO

Parent/Guardian Signature _____ Date _____

Dates _____
Updated _____