

GENERAL INFORMATION

School: _____

School Year: _____

Child's Name		Date of Birth
Parent/Guardian	Phone	Cell
Other Emergency Contact	Phone	Cell
Treating Physician	Phone	Allergies
Significant Medical History		
Describe any special considerations, limitations or precautions needed (regarding activities, sports, trips, food, etc.)		

SEIZURE INFORMATION - Please refer to the FPS SEIZURE QUESTIONNAIRE FOR PARENT/GUARDIAN for more info.

Seizure Type?	How Long?	How Often?	What happens?
Epilepsy Surgery (type, date, side effects)?		Child's Response or Care Needed AFTER Seizure?	
Device: <input type="checkbox"/> VNS <input type="checkbox"/> RNS <input type="checkbox"/> DBS Instructions: _____		Date Implemented _____	

SEIZURE RESPONSE - How to respond to a seizure (check all that apply)

- First aid – **Stay. Safe. Side.**
- Give rescue therapy according to this SAP (or SAP from Physician)
- Notify emergency contact from above
- 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 on **MY SEIZURE EVENT DIARY**
- 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

EMERGENCY MEDICATION INSTRUCTIONS IF SEIZURE OCCURS

For cluster # or length	Give Medication (Rx name)	Dose	Route

Parent/Guardian Signature: _____ Date _____

Treating Provider Signature: _____ Date _____