Deer Valley Unified School District No. 97

Student Seizure Information Sheet

(To be completed by parent prior to school entry)

Date: _____

Student Name: _____

Birthdate: _____ **Age:** _____

Teacher: _____ **Room Number:** _____

How long has your child had seizures?

_____

How often do the seizures occur?

_____

Has he/she been hospitalized in the past year to treat seizures? _____
If yes, when?

_____

Who is their physician?

_____

Physician phone number: _____

Please describe what happens during the seizure activity:

_____
_____
_____
_____
_____

What triggers the seizures? (example – noise, blinking lights):

_____
_____
_____

How long does the seizure activity last?

_____
_____

Call 9-1-1 if seizure activity does not stop after _____ minutes.

Are there any warnings and or behavior changes before the seizure? If yes, please describe:

_____
_____
_____

Does your child need any protective equipment (helmet) or activity adaptations at school? _____ If yes, what?

_____
_____
_____

How long after the seizure should your child wait until they return to regular school activities?

_____
_____
_____

What medication(s) is your child taking to treat the seizures?

Medication	**Dosage**	**Time (s)**

It is the responsibility of the parent to provide any medication that the child needs at school to treat seizure activity.

PLEASE ADVISE SCHOOL NURSE OF ANY MEDICATION CHANGES

STUDENT NAME_____ GRADE_____
TEACHER_____ BUS NUMBER _____

GENERAL TREATMENT PLAN FOR SEIZURE ACTIVITY AT SCHOOL

- **KEEP CALM**
- ***LOOK AT THE CLOCK - SAY THE TIME OUT LOUD***
- Begin timing the seizure
- Help child to the floor to help avoid injury.
- Turn the child the side so saliva can flow from mouth.
- Notify the nurse of seizure activity.
- Stay with the student during the seizure, provide comfort, and speak gently.
- Provide a safe environment by removing hazardous objects.
- **DO NOT RESTRAIN STUDENT. DO NOT PUT ANYTHING IN CHILD'S MOUTH.**
- Protect head from injury. Loosen tight clothing at neck and waist.
- Have another classroom adult remove/direct students from area or room.
- **Call 9-1-1 if any if the following occurs**:

  Seizure lasts longer than _____ minutes (per care plan)
  The child has difficulty breathing
  If color does not return to normal afterward
  Serious injury
  Other (please list)
  _____
- Notify parent of seizure activity.
- Provide rest after seizure. Reorient and reassure child.

Parent's additional information to be added to treatment plan:

_____
_____
_____

I consent to the release of the above information to be shared with teachers, bus drivers and other school personnel as a part of my child's School Care Plan for Seizures. I will notify the school nurse immediately of any changes in condition, medications, phone numbers, address, emergency contacts, doctor/hospital preferences.

Parent/guardian Signature _____ Date _____

School Nurse Signature _____ Date _____

Teacher Signature _____ Date _____

Teacher aide Signature _____ Date _____

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SCHOOL RECORD OF SEIZURE ACTIVITY

STUDENT: _____

DATE	TIME SEIZURE OCCURED	DURATION

What was the student doing before the seizure?

_____
_____

What did the student do during the seizure?

_____
_____
_____
_____

What was the child's behavior like after the seizure?

_____
_____
_____

Was the child injured during the seizure?

Who was notified?

_____
_____

Disposition:

□ Child remained in class

□ Sent home

□ Taken to hospital by _____

□ Copy of seizure activity record given to parent