Clinic Use LOCATION OF EMERGENCY MEDICATION AT SCHOOL: _____

GWINNETT COUNTY PUBLIC SCHOOLS
HEALTH AND SOCIAL SERVICES

SEIZURE

Health Management Plan

SCHOOL YEAR: _____

STUDENT NAME:	**DOB:**
SCHOOL:	**STUDENT ID:**

Parent/Guardian	**Parent/Guardian**
Phone:	**Phone:**
Phone:	**Phone:**
Emergency Contact:	
Name:	**Phone:**
Physician:	**Phone:**
Hospital Preference:	

SEIZURE Type(s): _____ Length: _____ Frequency: _____ Date of Last Seizure: _____

Description of seizure(s): _____

Seizure triggers/warning signs:

STUDENT HISTORY (including other medical conditions):

DAILY MEDICATIONS (include name, dose, frequency):

EMERGENCY MEDICATION:

OTHER TREATMENTS OR CONSIDERATIONS:

Basic Seizure First Aid

- Stay calm, observe, time
- Keep student safe if wandering or confused
- Stay with student until fully conscious
- Record seizure activity
- Contact parent/guardian

Tonic-Clonic (generalized) Seizure First Aid

- Call for clinic worker and remove bystanders
- Turn on side, protect head, remove potentially harmful objects, do not restrain, put nothing in mouth
- Keep airway open
- Contact parent/guardian
- Administer emergency medication as prescribed

CALL 911 if:

- Seizure lasts > 5 minutes
- Emergency medication is administered
- Injury occurred or suspected
- Breathing does not return to normal
- Student has diabetes

Parent/Guardian signature indicates acknowledgment and release for sharing medical information between our student's physician and other health care providers and authorizing the designated cluster nurse to share medical information with other school employees as necessary.

Parent/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____

School Clinic: Copy of plan to be provided to Transportation Supervisor

_____

CLUSTER NURSE SIGNATURE DATE

Information about students and family is strictly confidential.

Rev. 2/2024