Seizure Management for the School Setting

Contact Information

Student's Name: _____ Date of Birth: _____

School Year: _____ Effective Dates: _____

School: _____ Grade:_____ Classroom: _____

Parent/Guardian Name: _____ Tel. (H): _____ (W):_____ (C): _____

Parent/Guardian Name: _____ Tel. (H): _____ (W):_____ (C): _____

Other Emergency Contact:_____ Tel. (H): _____ (W):_____ (C): _____

Child's Neurologist: _____ Tel: _____ Location: _____

Child's Primary Care Dr.: _____ Tel: _____ Location: _____

Physician to provide the following information:

Seizure type/length/frequency: _____

Seizure triggers or warning signs:_____

Student's reaction to seizure:_____

General health: _____

Basic First Aid-Care and Comfort: (Please describe basic first aid procedures)

_____

_____

_____

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 (grand mal) seizure:

- ★ Protect head
- ★ Keep airway open/watch breathing
- ★ Turn child on side

Emergency Response for seizure:

A "seizure emergency" for this student is defined as: _____

_____

_____

Seizure Emergency Protocol: *(Check all that apply and clarify as needed*

☐Call 911 for transport to

☐Administer emergency medications as indicated below

☐Notify parent or emergency contact

☐Contact school nurse

☐Other

A Seizure is generally considered an Emergency when:

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

Restrictions on activity, including field trips, transportation, etc:

_____

_____

Student medication Information: _____

Medication Name: _____ Dose:_____

When to administer: _____ Given at school: ❑ Yes ❑ No

Instructions for administration: _____

Possible Side Effects: _____

Medication Name: _____ Dose: _____
When to administer: _____ Given at school: ❑ Yes ❑ No
Instructions for administration: _____
Possible Side Effects: _____

Emergency/Rescue Medication: _____ Dose: _____
When to administer: _____ Given at school: ❑ Yes ❑ No
Instructions for administration: _____
Possible Side Effects: _____

Does student have a **Vagus Nerve Stimulator (VNS)?** ❑ Yes ❑ No
If YES, Describe magnet use: _____

Parent to provide the following information:

1. When was your child diagnosed with seizures or epilepsy? _____
2. What might trigger a seizure in your child? _____
3. Are there any warnings and/or behavior changes before the seizure occurs? ❑ Yes ❑ No
   If YES, please explain: _____
4. When was your child's last seizure? _____
5. Has there been any recent change in your child's seizure patterns? ❑ Yes ❑ No
   If YES, please explain: _____
6. How does your child react after a seizure is over? _____
7. How do other illnesses affect your child's seizure controlL? _____

Special Consideration & Precautions:

Describe any considerations or precautions regarding the following:

❑ Physical functioning: _____
❑ Learning: _____
❑ Behavior: _____
❑ Mood/coping: _____
❑ Other: _____

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

Can this information be shared with classroom teacher(s) and other appropriate school personnel? ❑ Yes ❑ No

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations.

_____/_____ _____
Name Signature Date

Physician's Stamp (required)

Parent/Guardian (Authorization and Disclaimer): I request that the school assist my child with the above medications/treatments and the seizure action plan in accordance with state laws and regulations.

_____/_____ _____
Name Signature Date