



Great Falls Public Schools – Seizure Emergency Care Plan

Student Name:	ID:	School:	Grade:	Teacher:
DOB:	Plan Year:	School Nurse:	Phone#:	
Does the student have any of the following plan(s)? 504 Y/N IEP Y/N		Does the student ride the school bus? Y/N		
Parent/Guardian:		Phone #:		
Emergency Contact:		Phone #:		
Primary Provider:		Specialist:		
Drug Allergies:		Daily Medications:		

Last known Seizure:	Seizure Warnings:
Seizure Type:	What Happens:
How Often:	
Restrictions:	Triggers:
Special Devices/Equipment:	How long it Lasts:

<u>Protocol for Seizure During School</u> (check all that apply)	
☐ First Aid- STAY, SAFE, SIDE	☐ Contact school nurse at:
☐ Give rescue therapy according to ECP	☐ Call 911 for transport
☐ Notify parent/guardian contact	☐ Other:

Steps to take when seizure occurs during school day/activity:

- ☐ **STAY** calm, keep calm, **begin timing seizure**
 - ☐ Note the time seizure begins: _____
- ☐ Provide a **SAFE** area around students, remove harmful objects, don't restrain, protect head
- ☐ Lay them on their **SIDE**, do not restrain or place anything in their mouth
- ☐ **STAY** until recovered from seizure
- ☐ Note the time seizure ends: _____
- ☐ Notify parent/guardian.
- ☐ Call 911 if seizure is > _____ minutes OR for > _____ (#) seizures within _____ minutes.
- ☐ Administer Emergency Treatment as indicated to the right.

Emergency Treatment:

- ☐ Medication: _____

- Time to administer: _____

- Dose: _____
- Route: _____
- Location: _____
- ☐ Vagus Nerve Stimulator? Yes / No
- Instructions: _____

Parental Permission:

- ☐ As parent/guardian of above student, I consent for the employees of Great Falls Public School system to follow the plan and use the designated medications on my child in accordance with the instructions above.
- ☐ I understand that I am to provide the school with medication and signed authorization form, supplies, etc. to follow the plan.
- ☐ I understand that this plan will be shared to all those who need to know (all student's teachers/office personnel/ bus driver/ emergency responder, etc) unless written objection is stated on this form

I hereby acknowledge that I have read, understand, and support the Emergency Health Plan

Physician:	Date:	Building Administrator:	Date:
Parent/guardian:	Date:	School Nurse:	Date:

