NORTH MERRICK
UNION FREE SCHOOL DISTRICT
– Nurturing Young Minds –

NORTH MERRICK UNION FREE SCHOOL DISTRICT

NORTH MERRICK, NY 11566

SEIZURE DISORDER EMERGENCY CARE PLAN

Student: _____ Grade: _____ DOB: _____
Other medical diagnoses: _____
Daily medications: _____
Mother: _____ M Home # _____ M Work # _____ M Cell # _____
Father: _____ F Home # _____ F Work # _____ F Cell # _____
Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF A SEIZURE EPISODE MAY INCLUDE ANY/ALL OF THESE:

Tonic-Clonic (Grand mal) Seizure:
- Entire body stiffens, jerking movements
- May cry out, turn bluish, be tired afterwards

Absence (Petite mal) Seizure:
- Staring spell, may blink eyes, loss of eye contact
- Twitching of arm or leg muscles

Describe typical symptoms for this student: _____

TREATMENT: Call for help. Building emergency #_____ or school nurse _____

RECORD START TIME AND END TIME OF SEIZURE.
Remain calm.
Clear the area around the student to avoid injury. Remove classmates, when possible.
Gently lower the student to the floor, place student on side if possible, loosen restrictive clothing from neck.
DO NOT PUT ANYTHING IN THE STUDENT'S MOUTH.
Observe color of lips, face, and skin, body movements, and breathing.
Speak to student in reassuring tone. Stay with student until help arrives.
Roll student on side to prevent choking after seizure ends.
Emergency medication, if prescribed: _____
Contact parent (info above).
Student should be allowed to rest following seizure. Do not give fluids or food.

☐ **Emergency Medical Services(911) should becalled:**
If seizure lasts more than _____minutes, or
If one seizure is followed by another seizure, or
If student is not breathing after muscle spasms have ended, or
If student is injured or school is concerned about immediate health and safety of student.

Be prepared to start CPR if not breathing after seizure ends.

Healthcare Provider: _____ Phone: _____
Writtenby: _____ Date: _____
☐ Copy provided to Parent ☐ Copy sent to Healthcare Provider
Parent/Guardian Signature: _____ Date: _____

Signature authorizes school to share this information with school staff on a "need to know" basis and to communicate with healthcare provider about this plan. This plan is in effect for the current school year only.

Nurse Signature: _____ Date: _____

Form Updated: 6/9/14.