

## EMERGENCY CARE PLAN – SEIZURE DISORDER

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade/Teacher \_\_\_\_\_

School Name \_\_\_\_\_ School Year \_\_\_\_\_

### My child's seizure disorder includes: Check all that apply and fill in blanks.

MY CHILD'S TYPE OF SEIZURE AND BEHAVIOR	EMERGENCY CARE AT SCHOOL
<p><input type="checkbox"/> <b>Tonic/Clonic Seizure (Grand Mal)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Loss of consciousness</li> <li><input type="checkbox"/> Tremors</li> <li><input type="checkbox"/> Aura(warning) _____</li> <li><input type="checkbox"/> Muscle jerks</li> <li><input type="checkbox"/> Sudden cry</li> <li><input type="checkbox"/> Saliva on lips</li> <li><input type="checkbox"/> Bluish skin color</li> <li><input type="checkbox"/> Possible loss of bladder or bowel control</li> <li><input type="checkbox"/> Becoming rigid</li> <li><input type="checkbox"/> Usually lasts _____ minutes</li> <li><input type="checkbox"/> Confusion, muscle limpness and drowsiness after the seizure followed by full return of consciousness in _____ minutes</li> <li><input type="checkbox"/> Other seizure behavior: _____ _____</li> </ul>	<ul style="list-style-type: none"> <li>• Assist student to the floor, turn on side</li> <li>• TIME THE SEIZURE</li> <li>• Protect head from injury – place something soft under head</li> <li>• Call office _____.</li> <li>• Clear hazards (furniture or other objects)</li> <li>• Prevent injuries and treat any that occur</li> <li>• Have another adult direct students away from area</li> <li>• Do not attempt to put anything in their mouth or try to restrain in any way</li> <li>• <u>Administer emergency medication:</u>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</li> <li>If Yes: Name of medication _____</li> <li>Instructions _____</li> <li>• Contact parents immediately</li> <li><input type="checkbox"/> Other: _____</li> <li>• <b>Call 911 if one or more:</b> <ul style="list-style-type: none"> <li>• Single seizure lasts longer than 5 minutes</li> <li>• If multiple seizures occur</li> <li>• Student appears injured</li> <li>• Fails to regain consciousness after the seizure</li> <li>• Emergency medication is given</li> <li>• No pulse and/or breathing–<b>Start CPR immediately</b></li> </ul> </li> <li><input type="checkbox"/> Other: _____</li> </ul>

<p><input type="checkbox"/> <b>Partial, Absence or Unclassified Seizure</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Performs aimless activities                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Chewing</li> <li><input type="checkbox"/> Fumbling</li> <li><input type="checkbox"/> Wandering</li> <li><input type="checkbox"/> Shaking</li> <li><input type="checkbox"/> Confused speech</li> <li><input type="checkbox"/> Twitching of mouth or hands</li> </ul> </li> <li><input type="checkbox"/> Brief staring spell</li> <li><input type="checkbox"/> Usually lasts _____ minutes</li> <li><input type="checkbox"/> Consciousness is affected</li> <li><input type="checkbox"/> Other seizure behavior: _____ _____</li> </ul>	<ul style="list-style-type: none"> <li>• Do not hold down or grab</li> <li>• Protect from hazards and injuries</li> <li>• Time the seizure</li> <li>• Stay with student, speak gently and help student get back on task following seizure</li> <li>• Allow _____ minutes to rest and re-orient self before returning to class</li> <li><input type="checkbox"/> Report to parents:    <input type="checkbox"/> daily    <input type="checkbox"/> weekly    <input type="checkbox"/> immediately</li> <li><input type="checkbox"/> Other: _____</li> <li>• <b>Call 911 if one or more:</b> <ul style="list-style-type: none"> <li>• Full awareness does not return</li> <li>• Student appears injured</li> <li>• No pulse and/or breathing–<b>Start CPR immediately</b></li> </ul> </li> <li><input type="checkbox"/> Other: _____</li> </ul>
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If your child requires medication at school, you must have a **Prescription Medication Permission Form** signed by doctor and parent on file **BEFORE** the medication can be given.

**INDIVIDUALIZED HEALTH CARE PLAN – SEIZURE DISORDER CONTINUED**

Student Name \_\_\_\_\_

1. At what age did your child have their first seizure? \_\_\_\_\_
2. How often do the seizures occur? \_\_\_\_\_ Date of last seizure \_\_\_\_\_
3. Has your child ever had a seizure lasting longer than five minutes?  Yes  No
  - a. If yes, what needs to be done \_\_\_\_\_
4. What events might cause a seizure (such as fever, blinking lights, etc.)? \_\_\_\_\_  
\_\_\_\_\_
5. What safety precautions or activity restrictions are needed at school? \_\_\_\_\_  
\_\_\_\_\_
6. What is the date of your child's last medical evaluation for seizures? \_\_\_\_\_
7. Does your child take medication to control their seizures?  Yes  No
  - a. If yes, name of medication(s) and dose \_\_\_\_\_
  - b. Time(s) of day medication(s) are taken \_\_\_\_\_
8. What additional information will help school staff understand your child's seizure disorder plan?
  - Physical Education/Recess precautions \_\_\_\_\_  
\_\_\_\_\_
  - Transportation to and from school \_\_\_\_\_  
\_\_\_\_\_
  - Other concerns \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**We recommend that students with a seizure disorder wear a Medic-Alert bracelet/pendant at all times.**

School Nurse Signature \_\_\_\_\_ Date Reviewed \_\_\_\_\_