

# Health Plan for Seizures

(To be completed by parent and/or physician, physician signature required if medications are given at school.)

Student name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Grade: \_\_\_\_\_ School Year: \_\_\_\_\_ Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Parent(s): \_\_\_\_\_ Phone Numbers: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone Numbers: \_\_\_\_\_

## Current Medications

Medications Given at Home (list): \_\_\_\_\_  
 \_\_\_\_\_ Medication Allergies: (list) \_\_\_\_\_

The following medications are to be administered at school:

Medication Name: \_\_\_\_\_ Medication Name: \_\_\_\_\_  
 Dose: \_\_\_\_\_ Dose: \_\_\_\_\_  
 Time(s): \_\_\_\_\_ Time(s): \_\_\_\_\_

## Seizure Pattern

Types of Seizures	Description*
__Absence	<ul style="list-style-type: none"> <li>• Staring</li> <li>• Blinking</li> <li>• Loss of awareness</li> <li>• Other _____</li> </ul>
__Simple Partial	<ul style="list-style-type: none"> <li>• Remains conscious</li> <li>• Distorted sense of smell, hearing, sight</li> <li>• Involuntary rhythmic jerking/twitching on one side</li> <li>• Other _____</li> </ul>
__Complex Partial	<ul style="list-style-type: none"> <li>• Confused</li> <li>• Not fully responsive/unresponsive</li> <li>• May appear fearful</li> <li>• Purposeless repetitive movements</li> <li>• Other _____</li> </ul>
__Generalized tonic-clonic seizures	<ul style="list-style-type: none"> <li>• Convulsions</li> <li>• Stiffening</li> <li>• Breathing may be shallow</li> <li>• Lips or skin may have bluish color</li> <li>• Unconsciousness</li> <li>• Confusion, weariness, or belligerence when seizure ends</li> <li>• Other _____</li> </ul>

\*Student may experience some or all of the listed symptoms during a specific seizure

Seizure usually lasts \_\_\_\_\_ minutes Returns to baseline in \_\_\_\_\_ minutes

Possible warning and/or behavior changes prior to a seizure: \_\_\_\_\_

\*\*See Emergency Seizure Treatment Plan for seizure management.

**ACTIVITIES:** Student may participate in ALL activities at school. Yes \_\_\_\_\_ No \_\_\_\_\_

**OR**

List any activities that this student may not participate in at school. \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

# Emergency Seizure Treatment Plan

(To be completed by parents, physician signature required if medications or treatments are to be administered by school staff.)

Student name: \_\_\_\_\_ DOB: \_\_\_\_\_

Grade: \_\_\_\_\_ School Year: \_\_\_\_\_ Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent: \_\_\_\_\_ Phone Numbers: \_\_\_\_\_

Parent/ Emergency Contact: \_\_\_\_\_ Phone Numbers: \_\_\_\_\_

## Seizure First-Aid

1. Cushion the head, remove glasses.
2. Loosen any tight clothing.
3. Turn on side and keep airway clear.
4. Note the time the seizure starts and the length of the seizure.
5. Don't put anything in the mouth.
6. Don't hold down.
7. Reassure and offer help and rest.
8. Other: \_\_\_\_\_

## Treatments:

Oral Medications: (Include medication name, dosage, frequency, and reason)

Diastat (diazepam rectal gel) \_\_\_\_\_ mg rectally prn for:

Seizure > \_\_\_\_\_ minutes OR for \_\_\_\_\_ or more seizures in \_\_\_\_\_ hours.

Use VNS (vagal nerve stimulator) Magnet \_\_\_\_\_

Other: \_\_\_\_\_

## Call 911 if:

- Seizure does not stop by itself or with VNS within \_\_\_\_\_ minutes.
- Seizure does not stop within \_\_\_\_\_ minutes of giving DIASTAT.
- Student does not start waking up within \_\_\_\_\_ minutes after seizure is over (no DIASTAT given).
- Student does not start waking up within \_\_\_\_\_ minutes after seizure is over (after DIASTAT given).

## Following a seizure:

- Student should rest in Health Office
- Student may return to class
- Parents/caregiver should be notified immediately
- Parents/caregiver should receive a note/copy of the seizure record sent home with the student.
- Complete Seizure Record

Parent/Guardian Signature: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Reviewed by Licensed School Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

# Seizure Record

Instructions: Complete record, one form per seizure.

Student Name: \_\_\_\_\_ Date of Report: \_\_\_\_\_

Event	Time
Seizure Start	
Vagal nerve stimulator Yes No	
Diastat Yes No	
Other:	
Seizure End	
Health Office Notified	
Parent/Caregiver Notified	
<b>911 Called:</b> <input type="checkbox"/> Seizure does not stop by itself or with VNS within ___ minutes. <input type="checkbox"/> Seizure does not stop within ___ minutes of giving DIASTAT <input type="checkbox"/> Student does not start waking up within ___ minutes after seizure is over (no DIASTAT given) <input type="checkbox"/> Student does not start waking up within ___ minutes after seizure is over (after DIASTAT given)	

Where was the student when the seizure occurred? \_\_\_\_\_

Activities immediately preceding the seizure: \_\_\_\_\_

Noteworthy behavior immediately preceding seizure: \_\_\_\_\_

Description of Seizure Behavior: \_\_\_\_\_

Behavior after seizure:

- |                                     |   |                                       |                                      |
|-------------------------------------|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Drowsiness | <input type="checkbox"/> Slurred speech | <input type="checkbox"/> Irritability | <input type="checkbox"/> Nausea      |
| <input type="checkbox"/> Confusion  | <input type="checkbox"/> Unsteady walk  | <input type="checkbox"/> Inattention  | <input type="checkbox"/> Poor memory |

Comments: \_\_\_\_\_

Were there any injuries? \_\_\_ yes \_\_\_ no

Describe injuries: \_\_\_\_\_

Signed: \_\_\_\_\_ Title \_\_\_\_\_

Please turn completed form into health office.