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	• Staring • Blinking	• Loss of awareness • Other _____
__Simple Partial	• Remains conscious • Distorted sense of smell, hearing, sight	• Involuntary rhythmic jerking/twitching on one side • Other _____
__Complex Partial	• Confused • Not fully responsive/unresponsive	• May appear fearful • Purposeless repetitive movements • Other _____
__Generalized tonic-clonic seizures	• Convulsions • Stiffening • Breathing may be shallow • Lips or skin may have bluish color	• Unconsciousness • Confusion, weariness, or belligerence when seizure ends • Other _____

*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.

ACTIVITES: 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: _____