



SEIZURE HEALTH CARE PLAN

STUDENT INFORMATION

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____ Room: _____

Parent/Guardian: _____ Home Phone: _____

Address: _____ Work/Cell Phone: _____

Parent/Guardian: _____ Home Phone: _____

Address (if different): _____ Work/Cell Phone: _____

OTHER EMERGENCY CONTACTS:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Treating Physician: _____ Clinic: _____ Phone: _____

SEIZURE INFORMATION:

Age of Onset: _____

▪ Types of seizures usually seen: (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Tonic-clonic (grand mal) | <input type="checkbox"/> Simple | <input type="checkbox"/> Absence (petit mal) |
| <input type="checkbox"/> Myoclonic (minor motor) | <input type="checkbox"/> Febrile (fevers) | |
| <input type="checkbox"/> Astatic (drop) | <input type="checkbox"/> Partial onset-- generalized | |
| <input type="checkbox"/> Complex with preceding aura _____ | | |
| <input type="checkbox"/> Other _____ | | |

▪ Status Epilepticus: Yes No If yes, last occurrence: _____

▪ Date of last seizure: _____

▪ Usual signs and symptoms: (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Sensory or mental aura | <input type="checkbox"/> Purposeless movement | <input type="checkbox"/> Loss of awareness |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Fluttering eyelids | <input type="checkbox"/> Loss of control |
| <input type="checkbox"/> Falls down | <input type="checkbox"/> Change in learning performance | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Muscle rigidity (tonic phase) | <input type="checkbox"/> Rhythmic convulsions | <input type="checkbox"/> Headache (after) |
| <input type="checkbox"/> Twitching/jerking of body parts | <input type="checkbox"/> Repeating acts/movements | <input type="checkbox"/> Drowsy/sleepy |
| <input type="checkbox"/> Blank stare | <input type="checkbox"/> Aimless wandering | |
| <input type="checkbox"/> Other: _____ | | |

▪ Known triggers for seizures:

- | | | | | |
|--|---------------------------------------|---------------------------------|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Bright lights | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stress | <input type="checkbox"/> Loud noises | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Hunger | <input type="checkbox"/> Other: _____ | | | |

DAILY MANAGEMENT PLAN WHILE IN SCHOOL

Activity Restrictions: _____

Special Equipment Requirements: _____

Special Diet: _____

Daily Medications: (Name, dose, route, time given)

List Side Effects (if any):

- _____
- _____
- _____

- _____
- _____
- _____

BASIC SEIZURE FIRST AID PLAN:

- ✓ Stay calm and track time
- ✓ Keep child safe
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with child until fully conscious
- ✓ Record seizure in log

For tonic-clonic seizure:

- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

A SEIZURE IS GENERALLY CONSIDERED AN EMERGENCY WHEN:

- ✓ Convulsive (tonic-clonic) seizure lasts more than 5 minutes.
- ✓ Student has repeated seizures without regaining consciousness.
- ✓ Student is injured or has diabetes.
- ✓ Student has first-time seizure
- ✓ Student has breathing difficulties.
- ✓ Student has seizure in water.

▪ **NUMBER THE EMERGENCY ACTIONS IN ORDER TO BE FOLLOWED:**

- _____ Call parent/guardian
- _____ Call doctor
- _____ Call 911: Instruct transport to _____ Hospital.
- _____ Emergency medication:
 - Medication: _____
 - Dose: _____
 - Route: _____
 - May medication be repeated? Yes No When? _____

▪ **FOR ALL SEIZURES DOCUMENT THE FOLLOWING:**

- ✓ What happened before, during, and after the seizure
- ✓ Time seizure started
- ✓ Length of seizure
- ✓ What parts of body were involved and how

- We ask you to complete this form at the beginning of every school year to ensure that we have the most current information on your child.
- The school district intends to use the requested information to provide for child's health and safety while at school.
- The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety.
- If we are unable to reach you or your designee during an emergency, we will call 911 for assistance if needed.

I give permission for the school health services staff to consult with my child's physician about questions regarding the listed medication/medical condition

School Nurse: _____

Date: _____

Parent/Guardian: _____

Date: _____

Physician: _____

Date: _____