SEIZURE CARE PLAN FOR SCHOOL USE

Student Name: ____________________________________ Date of Birth: __________________________________

School: ____ Grade: ____________________

Parent/Guardian(s) Name: ___________________________ Physician's Name: _______________________________

Parent/Guardian(s) Phone: ___________________________ Physician's Phone: ______________________________

Allergies: ____ Home Rx(s): ____________________________________

Emergency Medication:	**Dose:**	**Route:**
Instructions for use:		

Description of Previous Seizure(s): ____

Please check	**Type of Seizure**	**Description**
	Focal Onset Aware (Simple Partial)	Begins in one area or group of cells in one side of the brain with no change in awareness.
	Focal Onset Impaired Awareness (Complex Partial)	Begins in one area or group of cells in one side of the brain with impaired awareness.
	Generalized Onset Motor (Grand Mal)	Affects both sides of the brain or groups of cells on both sides at the same time with motor activity involvement such as jerking [clonic], stiffness [tonic], loss of muscle control [atonic], or automatisms [repeated or automatic movements]
	Generalized Onset Non-motor (Absence)	Affects both sides of the brain or groups of cells on both sides at the same time and can involve autonomic system (breathing, pulse) behavioral arrest (speech or movement stopping), cognitive (slowed thinking or understanding), emotional (sudden fear, anxiety, or pleasure) or sensory changes (hearing, vision, taste, pain, numbness/tingling) changes.
	Unknown Onset Motor or Non-motor	When the beginning of a seizure is not known

Action Plan for Seizures

1. Protect student from injury and note the time
   - Lower student to floor
   - Loosen clothing around neck
   - Place on their side if able
   - Place soft item under head
   - Do not attempt to open or put anything in the student's mouth
   - Do not interfere with student's movements or attempt to restrain
   - Let the seizure run its course
2. Remove other students from the area
3. Call Parent/guardian
4. Call nurse
5. Observe and document details of seizure
   - Behavior before and after seizure
   - Length and characteristics of seizure

Emergency Treatment - Dial 911

- **If emergency medication has been administered**
- **If seizure lasts greater than 5 minutes**
- **If two or more consecutive seizures occur (with no waking in between) totaling ___ minutes or more**
- **For first time seizures**
- **If seizure is related to a head injury**
- **If student is having difficulty breathing**
- **Any concern with airway, breathing, circulation**
- **If a seizure occurs in the water**
- **Other:**_________________________________

Special Instructions

☐ Aura recognition: (Describe)____

☐ Avoid triggers: **(Circle)** flashing lights, sleep deprivation, low blood sugar, stress, other: __________________

As a parent/guardian of the above-named student, I give consent for an exchange of health information between the school nurse and healthcare provider. I give consent for exchange of information between the school nurse and appropriate school personnel. I authorize the administration of listed medication by trained school personnel. I acknowledge it is my responsibility to communicate any changes to my child's health condition, medications or needs to the school nurse. Orders are valid through the end of the current school year. *If your child in Medicaid eligible, school health services may be billed on behalf of the school. School district billing will not impact future benefits of your family's Medicaid plan. Orders are valid through the end of the current school year.

Parent Signature : ________________________ Printed Name : __________________________ Date : ________________

Physician Signature : ______________________ Printed Name : __________________________ Date : ________________