Picture if available

_____ DISTRICT
Health Services

HEALTH CARE PLAN FOR SEIZURE MANAGEMENT

Student: _____ Date of Birth _____ / _____ / _____

School: _____Teacher: _____Grade: _____ School Year: _____

Mother / Guardian's Name: _____
Home Address: _____ City / ZIP: _____
Home Phone: (____)_____ Cell phone: (____)_____ Pager: (____)_____
Work Phone: (____)_____ Work Hours: _____

Father / Guardian's Name: _____
Home Address: _____ City / ZIP: _____
Home Phone: (____)_____ Cell phone: (____)_____ Pager: (____)_____
Work Phone: (____)_____ Work Hours: _____

Primary Care Physician:_____ Phone:_____ **Hospital**: _____

Neurologist:_____ Phone:_____ Nurse: _____

Seizure Description

Seizure Type:_____

Description of Seizure: _____

_____

Possible Triggers: _____

Frequency of seizures: _____ per _____. Last date of seizure was _____

Average Length of Seizure Activity: _____ Usual time of day of Seizure Activity:_____

Average time until Student can return to Regular Activities: _____

Student's reaction to Seizure:_____

Medication

Daily Medication

Name of Medication	Dose	Route	Time of Day	Start Date	Stop Date
1.					
2.					
3.					
4					

Emergency Medication

Name of Medication	Dose	Route	Reason to be given

□

Student's Name:_____

First Aid

1. Keep calm and reassure other people who may be nearby.
2. Don't hold the person down or try to stop his movements.
3. Time the length of the seizure with your watch.
4. Clear the area around the person of anything hard or sharp.
5. Loosen ties or anything around the neck that may make breathing difficult.
6. Put something flat and soft, like a folded jacket, under the head.
7. Turn him or her gently onto one side. This will help keep the airway clear. Do not try to force the mouth open with any hard implement or with fingers. **It is not true that a person having a seizure can swallow his tongue.** Efforts to hold the tongue down can injure teeth or jaw.
8. Don't attempt artificial respiration except in the unlikely event that a person does not start breathing again after the seizure has stopped.
9. Stay with the person until the seizure ends naturally.
10. Be friendly and reassuring as consciousness returns.
11. Offer to call a taxi, friend or relative to help the person get home if he seems confused or unable to get home by himself.

Field trips School personnel will notify family of all field trips in advance and will take the following:

1. Cell phone
2. Copy of the student's management plan.
3. Emergency medication

Parent/Guardian Authorization

Student's Name: _____ Date of Birth: _____

I, the parent/guardian/student (if over 18 years of age) of the above named student, understand the health care services stated in the *Health Care Plan for Seizure Management* will be performed by designated school staff under the training and supervision provided by the school nurses (a registered nurse). I will notify the school in writing if there is any changes in my child's treatment plan. I will provide the necessary medication that need to be administered during the school day. The _____ School District has my permission to contact the student's physician or their designee about this treatment plan. For the student's safety, I authorize the release of this health plan to the following people:

☐ Principal(s) ☐ School office staff ☐ Health room staff ☐ Lunch room staff

☐ Play ground staff ☐ Hall monitors ☐ Educational assistants ☐ Bus Company

☐ Classroom teachers (school nurse will list by name when form received)

_____

_____

☐ Other

_____

Signature:_____ _____ _____

Parent/Guardian Signature Relationship Date

Physician Authorization

I have reviewed and approved the *Health care Plan for Seizure Management* for the student named above. I understand that designated school district personnel under the training and supervision provided by the school nurse (a registered nurse will perform specialized health care services. I agree to be contacted by the _____ School District with regard tot his plan. This consent remains in effect to the end of the current school year unless it is discontinued or changed in writing.

Signature:_____ _____

Physician's Signature Print Physician's Signature

Date:_____ **Phone:** _____

Area below for district use:

Date received:_____ Reviewed by:_____