EMERGENCY PLAN – SEIZURE DISORDER

CONFIDENTIAL

Student's Name_____Grade_____School_____ year_____

Parent/Guardian_____Phone # Work_____Home #_____

Physician_____Phone #_____

Physician treating seizures_____Phone #_____

Family member/Friend, aware of child's condition. Name_____Phone#_____

Please tell us what you want us to do in case of a seizure at school.
(Please check all that apply)

My child's seizure includes:

__ **Absence (petit mal) seizure**, Brief staring spell

__ **Partial seizure**: may walk around perform aimless activities_____
_____

__ **Convulsive seizure:**

___ Sudden cry, fall, rigidity, followed by muscle jerks, saliva on lips, bluish skin color.
__ Possible loss of bladder or bowel control
__ Some confusion, headache, and fatigue, followed by full return to consciousness
__ Other_____
_____
_____

Do this

__ Do nothing
__ Report to parents: daily / Weekly

__ Do not restrain
__ Report to parent immediately
__ Send note home to parent
__ Allow_____minutes to rest
__ Other_____
_____

__ Monitor
__ Observe symptoms
__ Notify parent ASAP
__ Administer medication
__ Allow to rest
__ Send note home

Follow General First Aid guidelines:

__Place folded towel under head
__Protect from nearby hazards
__Do not attempt to put anything in mouth
__Treat injuries that may have occurred
__Allow_____minutes to rest and re-orient self/return to class.
__ If single seizure lasts more than _____minutes, call parents/911
__If multiple seizures occur call parents/911

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How long has your child had seizures?_____

How do other illnesses affect your child's seizure control?_____

_____

Are there any warning and /or behavioral changes before the seizure?_____

_____

Please describe what happens during a seizure_____

_____

How long does a seizure last?_____

How often does your child have seizures?_____

Date of last seizure?_____

How often does your child see the doctor regarding seizures?_____

_____Date of last appointment_____

Will your child need to take medication during school hours? _____YES _____NO

If yes, you must have a medication consent form signed by you and your child's doctor on file for this school year and a medication supply must be kept at school for your child to participate in field trips/extracurricular activities.

Check any special considerations related to your child's epilepsy while at school and describe them briefly.

❑ Educational concerns_____

_____

❑ Behavioral/Emotional Concerns_____

_____

❑ Physical Education/Recess Precautions_____

_____

❑ Special transportation to and from school_____

_____

Any additional information_____

Parent Signature_____Date_____

School Nurse Signature _____ Date of review_____

Physician Signature _____Date _____