EMERGENCY PLAN – SEIZURE DISORDER

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:	**Do this**
☐ **Absence (petit mal) seizure**, Brief staring spell	☐ Do nothing ☐ Report to parents: daily / weekly
☐ **Partial seizure**: may walk around perform aimless activities_____ _____ _____ _____	☐ Do not restrain ☐ Report to parent immediately ☐ Send note home to parent ☐ Allow _____ minutes to rest ☐ Other_____ _____
☐ **Convulsive seizure**: ☐ Sudden cry, fall, rigidity, followed by muscle jerks, saliva on lips, bluish skin color. ☐ Possible loss of bladder or bowel control ☐ Usually lasts_____ minutes ☐ Some confusion, headache, and fatigue, followed by full return to consciousness ☐ Other _____ _____ _____	☐ Notify parents immediately ☐ Send note home ☐ **Follow General First Aid guidelines:** ∗Protect from nearby hazards ∗Place folded towel under head ∗Do not attempt to put anything in mouth or try to restrain in any way. ∗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

Comments: _____
_____
_____

Parent Signature_____Date_____

School Nurse Signature _____Date of review_____

CONTINUE ON THE OTHER SIDE

SEIZURE DISORDER

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_____

_____