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_____

_____