

SEIZURE EMERGENCY CARE PLAN

This plan is valid for the current school year: 20 - 20 Date of Plan: STUDENT INFORMATION DOB Grade Teacher Name Significant medical history: **CONTACT INFORMATION** Phone Mobile: Parent/Guardian Phone Mobile: **Emergency Contact** Physician/Health Care Provider Preferred Hospital **SEIZURE INFORMATION SEIZURE TYPE LENGTH FREQUENCY DESCRIPTION** Seizure triggers or warning signs: Last seizure: Student's response after a seizure: **BASIC FIRST AID: CARE & COMFORT** · Stay calm and track time For generalized seizure: Does student need to leave the classroom after a seizure? · Protect head Keep child safe Yes Nο · Do not restrain Keep airway open/ If yes, describe the process for returning student to classroom: · Do not put anything in the mouth watch breathing · Stay with child until fully conscious · Turn child on side · Record seizure in log **SEIZURE EMERGENCY PROTOCOL** A SEIZURE IS GENERALLY CONSIDERED AN EMERGENCY WHEN: Check all that apply & clarify below Contact school nurse at: Convulsive generalized seizure lasts longer than 5 minutes Call 911 if seizure lasts longer than: Student has repeated seizures without regaining consciousness Notify parent or emergency contact · Student is injured or has diabetes · Student has a first-time seizure Administer emergency medications as indicated below · Student has breathing difficulties Notify doctor · Student has a seizure in water Other: PHYSICIAN'S AUTHORIZATION FOR EMERGENCY MEDICATION ADMINISTRATION **EMERGENCY MEDICATION DOSAGE** TIME COMMON SIDE EFFECTS/SPECIAL INSTRUCTIONS Physician's signature X Date Physician (printed name) Clinic Phone TREATMENT PROTOCOL If medications are to be given during school, an Authorization to Administer Medication form MUST be completed. **MEDICATION DOSAGE** TIME OF DAY GIVEN COMMON SIDE EFFECTS/SPECIAL INSTRUCTIONS Does student have a Vagus Nerve Stimulator? Yes No If yes, describe magnet use: **SPECIAL CONSIDERATIONS & PRECAUTIONS** (regarding school activities, sports, field trips, etc.)

AUTHORIZATION FOR STAFF ADMINISTRATION OF MEDICATION

I give permission for the school nurse to consult with my child's physician concerning any questions that arise with regard to the listed medication or my child's medical condition. I understand that trained school personnel (e.g. classroom teacher, paraprofessionals, health office staff, office staff) will follow the Seizure Emergency Care Plan as completed by my child's physician, Licensed School Nurse, and myself.

Parent/Guardian signature	Date ,	/ /	'
Licensed School Nurse signature	Date /	/ /	,