Holly Area Schools

SEIZURE Medical Care Plan

Care plan is valid for one calendar school year and must be updated by physician with any changes made to medication dose or frequency throughout the school year.

Student's Name: _____ School Year :_____

Date of Birth: _____ School/Program: _____

Age: _____ Grade: _____ Teacher: _____

Page one of this care plan is to be completed, signed and dated by a parent/guardian.
Page two of this care plan is to be completed, signed and dated by the treating physician/ licensed prescriber.
Without **both** signatures this care plan is not valid. Parent/guardian is responsible for supplying all medication & any other supplies required.

Contact Information

First Contact	**Second Contact**
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone (1): _____	Phone (1): _____
Phone (2): _____	Phone (2): _____

Third Contact
(If a parent/guardian cannot be reached, must be listed on emergency card)

Name: _____ Phone: _____ Relationship: _____

Signs/Symptoms of seizure activity may include (please circle indicators for student):

1. Blank Staring
2. Rapid eye blinking
3. Drooling
4. Clenching hands
5. Stiffening of body
6. Shaking/twitching of extremities
7. Nonsense speech
8. Drooping of the mouth or cheek
9. Repetitive movement of a body part
10. Grinding Teeth
11. Uncontrolled shaking of 1 or more body parts
12. Student may fall down or lose consciousness

Other:_____

How long does a typical seizure last:_____ Frequency: _____ Date of last seizure: _____
Warning Signs (aura) or triggers if any, please explain:_____
Age when seizures were diagnosed: _____ Date of last exam: _____ Ketogenic diet: ☐ YES ☐ NO
Past history of surgery for seizures ☐ YES ☐ NO Does student have a Vagal Nerve Stimulator? ☐ YES ☐ NO
Student's reaction to seizure_____
Does the student need to leave the classroom after a seizure? ☐ YES ☐ NO
If yes, describe process for returning to classroom_____

I agree to have the information in this two page plan shared with staff needing to know. I understand that my child's name may appear on a list with other students having seizures to better identify needs. I give permission for trained staff to administer any medication ordered for seizure activity in this two page plan and to contact the ordering physician/licensed prescriber for clarification of this plan, if needed.

☐ YES ☐ NO I have read the attached information regarding section 504 eligibility
☐ YES ☐ NO I wish to be contacted regarding a 504 evaluation

_____ _____
Parent Signature **Date**

Holly Area Schools do not have medical personnel present to administer medication / treatment.

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If appropriate, please order medication / treatment to be administered at home.

Seizure Medical Care Plan

Student Name: _____ **Date of Birth:** _____ **School Year:** _____

Action if student has a seizure: - Remain calm & keep track of when the seizure started and length of time - Protect/cushion head - Lower to ground and turn onto their side - Do not restrain or put anything in mouth - Stay with child and provide reassurance - Follow medical treatment below	- **Call 911 first**, then parent/district nurse. (discretion of EMS transport will be made based on provider orders and discretion of EMS personnel and parent. Without parental availability, student will be transported to hospital per district policy. - Administer emergency medication/procedure, if seizure activity last longer than time indicated below - Document seizure on seizure activity log

General Signs of a Seizure EMERGENCY

- Convulsion/seizure activity lasts longer than instructions listed below by physician
- Student has repeated seizures (starts another seizure right after the first)
- Student is injured or has diabetes
- Student has breathing difficulties
- Student has a seizure in water

ACTION - CALL 911

✓ Stay with student until help arrives

✓ Call Parent/Guardian

✓ CPR if needed

Physician/Licensed Prescriber Order & Agreement with Protocol (as outlined in the 2 page plan)

☐ Administer_____for a seizure lasting **longer than**_____minutes. **Dose**_____

Route: _____ Other instructions: _____

☐ Administer Diastat® rectal gel for seizure lasting **longer than** _____ minutes. **Dose**_____

Other instructions:_____

Does student have a Vagal Nerve Stimulator ☐ YES ☐ NO (If YES, please describe magnet use below)

_____

☐ Student has a severe seizure disorder and it may be common for student to have multiple mini seizures or seizure like activity per day. If _____ seizures occur within _____ (time), **Please do the following:**

☐ Administer emergency medication ☐ Call 911 ☐ Notify parent to pick student up ☐ Other: _____

Call 911 if: (please check and complete)

☐ Seizure does not stop by itself within _____ minutes
☐ Anytime an emergency medication is given to stop a seizure
☐ Only if a seizure does not stop within _____ minutes after giving medication
☐ If any seizure activity is noted

Other directions: _____

Post seizure care: (please check)

☐ Student may return to class, if student is feeling well enough
☐ Student should be sent home with parent or guardian

Physician/Licensed Prescriber Name (Print): _____

Phone Number: _____ **Fax Number:** _____

Signature: _____ **Date:** _____