



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 and three 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 with the original pharmacy label & any other supplies required.

Contact Information

First Contact

Second Contact

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

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

- | | |
|-------------------------------------|--|
| 1. Blank Staring | 7. Nonsense speech |
| 2. Rapid eye blinking | 8. Drooping of the mouth or cheek |
| 3. Drooling | 9. Repetitive movement of a body part |
| 4. Clenching hands | 10. Grinding Teeth |
| 5. Stiffening of body | 11. Uncontrolled shaking of 1 or more body parts |
| 6. Shaking/twitching of extremities | 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 certify that I have legal authority to consent to medical treatment/care for the student named above, including administration of medications at school. I agree to have the information in this care plan to be shared with staff needing to know. I give permission for trained staff to administer medication ordered for seizure activity and to contact the ordering physician/licensed prescriber for clarification of this plan, if needed. I will not hold the HAS Board of Education, its personnel, or employees responsible for complications related to medication or treatment/care administered pursuant to this plan.

Parent Signature

Date



Holly Area Schools

Seizure Medical Care Plan

Holly Area Schools is not a medical facility. To the extent practicable and safe for the student, medication should be administered during non-school hours.

Student Name: _____

Date of Birth: _____ School Year: _____

Physician/Licensed Prescriber Order & Agreement with Protocol (as outlined in the 3 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 _____ **Route:** Rectal Other instructions: _____

Student have a Vagal Nerve Stimulator: YES NO (If YES, please describe magnet use): _____

Student has a severe seizure disorder. It may be common for the student to have **multiple** cluster 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

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): _____

Signature: _____ **Date:** _____

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



<p><u>Action if student has a seizure:</u></p> <ul style="list-style-type: none">- 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	<ul style="list-style-type: none">- Call 911 first, then parent/district nurse (discretion of EMS transport will be made based on provider orders, discretion of EMS personnel and parent). Without parental availability, the 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
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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