This page to be completed by Parent/Guardian

Student Name _____ School Year_____

Child's Picture

Warren Woods Public Schools

Seizure School Health Plan

Student Name_____

Date of Birth _____ Age_____ Grade ___ School_____

Note: This school health plan must be signed by parent and physician/licensed prescriber. Without signatures this plan is not valid.

CONTACT INFORMATION

	Call First	**Try Second**
Parent/ Guardian:	Name:_____	Name:_____
	Relationship: _____	Relationship: _____
Phone:	Home: _____	Home: _____
	Cell: _____	Cell: _____
	Work: _____	Work: _____

Call Third (If Parent/guardian cannot be reached)

Name: _____ Relationship: _____

Address: _____ Phone: _____

SEIZURE HISTORY

Seizure Type
Description of seizure _____

How long does a typical seizure last _____ **How often do seizures occur** _____

Date of last seizure _____

Warning signs (aura) or triggers if any, please explain _____

Age when seizures were diagnosed _____ **Date of last exam for this condition** _____

Past history of surgery for seizures ___ Yes ___ No

Current Seizure Medications _____

Notify parent immediately for all seizure activity? ___ Yes ___ No

Other instructions _____
Any special considerations or safety precautions:

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 in an emergency. I give permission to use my child's picture on this plan (if I did not supply a photo.) **I give permission for trained staff to help administer medication ordered for seizure activity and to contact the physician/licensed prescriber for clarification of orders & medical information if needed.**

Date: _____ Parent/Guardian Signature: _____

Revised 6/12

This page to be completed by Physician/Licensed Prescriber

Student Name _____ School Year_____

Action if student has a seizure:

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully awake
- Record seizure in a log

If tonic clonic (grand mal) seizure:

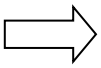
- Keep airway open/watch breathing
- Protect head
- Turn child on side, if able to safely
- Follow medical orders (last box below)

After Seizure:

- Permit student to rest
- Continue to document the episode
- Monitor for confusion or lack of consciousness
- Monitor breathing
- Do not give student anything to eat or drink until fully conscious and aware of surroundings

General Signs of a Seizure EMERGENCY

- Convulsion (tonic-clonic/grand mal) or per 911 instructions below in Order
- Student has repeated seizures without regaining consciousness
- Student is injured, has diabetes, or is pregnant
- Student has breathing difficulties, or normal breathing does not resume
- Student has a seizure in water
- Parents request an emergency evaluation



ACTION: CALL 911

- ✓ **Stay with the student until help arrives**
- ✓ **Call parent/guardian**
- ✓ **CPR if needed**

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

___ Administer Diastat rectal gel for seizure lasting longer than _____ minutes. Dose _____
Other instructions for Diastat _____

___ No Diastat ordered

Does student have a Vagal Nerve Stimulator ___ Yes ___ No (If YES, special instructions:

Call 911 if: (please check and complete all that apply)

- ⌗ **Seizure does not stop by itself within _____ minutes**
- ⌗ **Anytime Diastat is given**
- ⌗ **Only if a seizure does not stop within _____ minutes after giving Diastat**
- ⌗ **Other directions or medications:**

_____
_____

Physician/Licensed Prescriber's Name _____

Phone Number _____ Fax Number _____

Signature _____ Date_____