WARREN WOODS PUBLIC SCHOOLS
SEIZURE HEALTH PLAN

Student Name: _____ Birthdate:_____ Grade:_____ School Year:_____

School:_____ Date Form Received by School:_____

Note: This school health plan must be signed by a parent and physician/licensed prescriber in order to be valid. Without both signatures, 911 will automatically be called at first sign of seizure activity.

SEIZURE HISTORY & STUDENT SPECIFIC INFORMATION -

Seizure Type/Description of Seizure**:**_____

Length of time a typical seizure lasts:_____ How often do seizures occur:_____

Warning signs/aura to seizure activity:_____

Date of last seizure:_____ Date of last exam for this condition:_____ Age of seizure diagnosis:_____

Past history of surgery for seizures: __Yes __No Devices: __VNS __RNS __DBS - Placement date:_____

Diet Therapy: ___Ketogenic ___Low Glycemic ___Modified Atkins ___Other (describe):_____

Important medical history:_____

Other instruction/special considerations/precautions:_____

RESCUE THERAPY – ***this portion to be filled out by physician/licensed prescriber***

1. If seizure (cluster, type, #, or length): _____

Medication to be given**:**_____ How much to give (dose)**:**_____

How to give**:**_____

2. If seizure (cluster, type, #, or length): _____

Medication to be given**:**_____ How much to give (dose)**:**_____

How to give**:**_____

EMERGENCY CONTACTS –

Call First	**Call Second**	**Call Third**
Name**:**_____	Name**:**_____	Name**:**_____
Relationship**:**_____	Relationship**:**_____	Relationship**:**_____
Home**:**_____	Home**:**_____	Home**:**_____
Cell**:**_____	Cell**:**_____	Cell**:**_____
Work**:**_____	Work**:**_____	Work**:**_____

Reference: Epilepsy Foundation; epilepsy.com

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Seizure First Aid

*__STAY__ calm, keep calm, begin timing seizure

*Keep student __SAFE__ – remove harmful objects, don't restrain, protect head

*__SIDE__ – turn on side if not awake, keep airway clear, don't put object in mouth

*__STAY__ until recovered from seizure

*Write down what happens and when the seizure stopped

Responding to a Seizure

First Aid – Stay. Safe. Side.
Give rescue therapy as indicated
Notify emergency contact
Call 911

After a Seizure

Encourage rest
Continue to observe student & document episode
Monitor breathing, for confusion, or lack of consciousness
DO NOT give the student anything to eat or drink until fully conscious

A seizure is an emergency/call 911 when:

The seizure is accompanied by loss of consciousness, the student is not responding to the rescue medication, repeated seizures without regaining consciousness, difficulty breathing after a seizure, seizures in water, seizures in a diabetic or pregnant student, the seizure is convulsive

Physician/Licensed Prescriber order and agreement with this two-page protocol

Please check all that apply:

___ Administer _____(medication/dose) _____ (route) for seizures lasting longer than _____ minutes.

___ No emergency rescue medication ordered at this time.

___ The student may return to class/normal activity upon return to baseline and only if rescue medication has not been administered.

___ Does student have a VNS/DBS/RNS ___Yes ___No

If yes, please provide instructions:_____

Call 911 if (please check ALL that apply):

___ Seizure does not stop by itself within _____ minutes.

___ Anytime indicated rescue medication is administered (see above).

___ ONLY if a seizure does not stop within _____ minutes after giving indicated rescue medication (see above).

___ Anytime the student has a seizure at school.

___ Other directions or medications: _____

Physician/Licensed Prescriber (printed):_____ Phone:_____

Physician/Licensed Prescriber Signature:_____

I give written authorization for the medication(s) listed in this plan to be administered, in school, by trained staff members, as appropriate and as ordered. I understand that my child's name may appear on a list with other students who have a seizure disorder, in order to better identify needs in an emergency. I consent to communication between the prescribing health care provider/clinic and trained school personnel for clarification of orders and medical information if needed.

Parent Signature: _____ Date:_____

Reference: Epilepsy Foundation; epilepsy.com

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