SEIZURE INDIVIDUAL HEALTH PLAN

(Parent/guardian to complete this form)

STUDENT NAME _____ DOB _____ SCHOOL _____

GRADE _____ TEACHER _____ SCHOOL YEAR _____

PARENT/GUARDIAN _____ BEST CONTACT/PHONE NUMBER _____

PHYSICIAN _____ PHONE _____

NEUROLOGIST _____ PHONE _____

Please describe what usually happens during and after your child's seizure(s):

How often does your child have seizures?

How long do they usually last?

What triggers or causes the seizure(s)?

Does your child have an aura or warning of an on-coming seizure? ☐ Yes ☐ No If yes, please describe:

Are they able to notify anyone of an on-coming seizure? ☐ Yes ☐ No

Does your child take a medication at home every day to keep their seizures controlled? ☐ Yes ☐ No
If yes, what medication?

Does your child have a doctor's order for emergency medication for a seizure to be given at school, like Diastat, and is the medication at school? ☐ Yes ☐ No

Does your child have a Vagus Nerve Stimulator (VNS)? ☐ Yes ☐ No

In the event that you cannot be reached, please list the name(s) and phone number(s) of persons who are familiar with your child's seizures and have knowledge of how to manage a seizure. *Please also add this person(s) to your child's pickup list in case they may need to pick your child up from school due to their seizures.*

Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

Is there anything else you would like school staff to know about your child's seizures?

PLEASE NOTE: We recommend an Emergency Action Plan, completed by a doctor, for all children with seizures. Please review the back of this form for steps school staff may take in the event of a medical emergency. These will be followed if your child does not have an Emergency Action Plan at school for this condition.

☐ I give permission for my child, _____, to receive care for the medical condition listed above by designated school staff.
☐ School nurse may share information regarding this condition with my child's doctor.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

SCHOOL NURSE SIGNATURE _____ DATE _____

SEIZURE INDIVIDUAL HEALTH PLAN

Emergency: Seizure

STUDENT NAME _____

SEIZURE TRIGGERS _____

Note: If student also has an Emergency Action Plan (EAP) for this condition, please refer to the EAP for actions school staff should take instead. Otherwise, follow the steps below.

This student has an EAP: ☐ Yes ☐ No

Symptoms:

☐ Staring
☐ Jerking movements of the arms and legs
☐ Stiffening of the body
☐ Loss of consciousness
☐ Breathing problems or breathing stops
☐ Loss of bowel or bladder control
☐ Falling suddenly for no apparent reason
☐ Not responding to noise or words for brief periods
☐ Appearing confused or in a haze
☐ Nodding head
☐ Periods of rapid eye blinking and staring
☐ Lips may become bluish
☐ Other: _____

Interventions:

1. Stay with student; student should not leave location or be left alone.

2. Assist student to horizontal position and turn onto side as soon as able (into recovery position).

3. Call 911. Notify front office to direct EMS to student's location.

4. Clear area around student of objects and people. Do not restrain student's movement or place anything in mouth. Remove glasses if wearing and loosen clothing around neck.

5. Note time seizure started and stopped, if able, and observations of what the seizure looked like.

6. Call or radio for help. Designated first responder school staff should respond to the student's location, and bring any needed emergency equipment.

7. Notify parents/guardians, or designate another staff member to notify:

   Parent/guardian name: _____ Phone number: _____

   Emergency contact name: _____ Phone number: _____

8. Notify school nurse, if in building. If school nurse is not present, notify upon return or via other communication.

Additional information:

_____

_____

Reference: https://www.chop.edu/conditions-diseases/seizures-and-epilepsy Revised 4/2020 ALB