SCHOOL DISTRICT OF THORP
Student Health Services

School Year _____ **SEIZURE HEALTH ACTION PLAN**

Student Name _____

Date of Birth _____ Grade _____ Grad Year _____

School _____ Teacher/HR _____

PARENT / GUARDIAN EMERGENCY CONTACT INFORMATION:

Please provide phone numbers in order of where we can reach you during the school day in case of emergency.

Phone 1. _____	H/C/W	Name/Relationship	_____
Phone 2. _____	H/C/W	Name/Relationship	_____
Phone 3. _____	H/C/W	Name/Relationship	_____
Phone 4. _____	H/C/W	Name/Relationship	_____
Email for Health Plan updates:			

Physician student sees for Seizures _____ Phone _____

SEIZURE INFORMATION

Seizure Type	Length	Frequency	Description

Receiving Treatment? Yes___ No____ If febrile seizures, temperature at which they occur ____F

Seizure History: _____

_____

Significant Medical History: _____

_____

Seizure Triggers or Warning Signs: _____

_____

Likelihood and Frequency of Seizures During School Hours: _____

_____

Please specify any special considerations or concerns related to your child's seizure while at school, i.e., dietary, educational, behavior, recess, physical education, classroom precautions, school activities, sports, trips ect.: **(Note: Activity restrictions specified by physician need to be in writing and signed by the doctor).**

_____

_____

_____

Seizure Medications Given at **Home** (name, dose, frequency)

_____

_____

(SEE NEXT PAGE FOR EMERGENCY MEDICATIONS TO BE GIVEN AT SCHOOL)

NOTE: Parents are responsible for providing medications given at school. A Medication Authorization Form needs to be filled out and signed by a parent/guardian and health care provider annually.

PLEASE COMPLETE AND SIGN NEXT PAGE →

Student Name _____

EMERGENCY ACTION PLAN

NOTE: Care during a seizure is intended to keep the student safe, and when necessary, to stop a seizure. Most seizures stop on their own within 3 minutes.

Care and Comfort

- Stay calm and note the time that seizure began on the Seizure Observation Record
- **Call a Medical Emergency Response if you do not feel comfortable responding to a seizure**
- Retrieve student's emergency seizure medication, if at school.
- Do not try to stop the movements. Keep the child safe.
- Clear the area around the student of any hard, sharp, or hot objects.
- If walking around, gently lead student from dangers, such as doors or stairways
- Place something flat and soft beneath the student's head.
- Do not put anything in the mouth or between the teeth
- For a convulsive (tonic-clonic) seizure, gently roll the student onto one side and watch breathing closely
- Administer Emergency Medication as prescribed for seizure lasting longer than 5 minutes.
- Stay with the student until the seizure is over and they can respond when you talk with them.
- Allow them to rest or go home if too fatigued to work successfully in the classroom
- Document time, response, medications, ect. on the Seizure Observation Record.
- Notify parent/guardian and notify the school nurse
- Complete an Accident/Incident Report **and** Medical Emergency Response Team Report (if called)

Student has seizure emergency medications Yes____ No____

Medications (Name/Dose/Route):

_____

Special Instruction _____

_____

Call 911

- **If seizures are convulsive (tonic-clonic) seizure lasting longer than 5 minutes**
- **If DiaStat or other emergency medication was administered**
- **If seizures are consecutive (occurring one after the other)**
- **If student has a fist time seizure**
- **If student appears bluish or gray after the seizure ends or has difficulty breathing**
- **If student was injured during the seizure**
- **If student might be pregnant or has Diabetes**

Memo of Understanding:

- It is understood that a parent will complete and sign a Seizure Health Action Plan annually.
- It is understood that a parent will provide emergency medications needed at school.
- Is it the responsibility of the parent to notify the school nurse of any changes in the health plan.

This plan and medication will be used in case of emergency and accompany student off school property. This information may be shared with the classroom teacher(s), administrators, aides, bus driver, and other appropriate school personnel with a need to know.

Parent/Guardian Signature: _____ Date _____

School Nurse: _____ Anna Lisiecki, BSN, RN