

Seizure Care Plan

Student's Name: _____

Grade: _____ Div: _____

Facility Name: _____ Facility Address: _____

Student's Full Name: _____

Date of Birth: _____

Parent/Guardian: _____

Phone (home/cell): _____

Phone (work): _____

Emergency Contact: _____

Phone (home): _____

Phone (work): _____

Health Care Provider: _____

Phone: _____

Picture ID

HISTORY:

Type of Seizure: _____

Date of last seizure: _____

How often do they occur: _____

Student wears a Medic-Alert

Is the student taking medication Yes No

If Yes name of medication: _____

Dose: _____

How long have they been taking this medication: _____

Additional Information about medication: _____

USUAL SEIZURE PRESENTATION:

What happens during a seizure: _____

Warning signs before a seizure: _____

CARE PLAN INFORMATION:

Names of staff oriented to plan: _____

Emergency plan review date (to do yearly): _____

EMERGENCY TREATMENT FOR SEIZURES:

- Keep Calm.
- Do not restrain student during the seizure
- Protect student from injury:
 - Move hazardous objects out of the way
 - Lower student to the floor
 - Gently roll the student onto their side
 - Protect head
 - Do not put anything in the student's mouth
- Stay with student and provide reassurance and privacy
- **Call 911 if:**
 - Seizure lasts longer than 5 minutes,
 - Student has several seizures in a row without recovery
 - When unsure how long convulsions have lasted
 - Confusion persists for more than 20 mins after seizure
 - When a seizure occurs in water
 - If student is injured, pregnant or has diabetes
- Notify parent/guardian

It is the parent's responsibility to notify the facility of any change in the child's condition.

Sign below if you agree with above Information & Plan:

Health Care Provider (eg. Dr/Specialist/NP)

Date

Parent/Guardian

Date

Childcare Supervisor/School Personnel

Date