SEIZURE MANAGEMENT PLAN
SCHOOL YEAR: ____________

STUDENT NAME:	DOB:
SCHOOL:	STUDENT ID:

MOTHER:	FATHER:	
HOME PHONE:	HOME PHONE:	
WORK:	WORK:	
CELL:	CELL:	
EMERGENCY CONTACT:		PHONE:

NEUROLOGIST:	PHONE:	FAX:

Medical Conditions:____

Seizure History:

- Date of first seizure_________________
- Average length of time seizure lasts_______________________
- How often do seizures occur__________
- Usual time of day seizures occur _________________________
- Average time before student returns to regular activities after seizure __________________________________
- Things that may trigger a seizure____
- Possible warning and/or behavior changes prior to seizures____
  ____
- Description of seizure____
- Date of last seizure____

Additional information____

Medications (list all medications taken):	**Dose:**	**Time:**
Emergency medication:____________		As needed: see below

MANAGEMENT PLAN FOR SCHOOL (what to do if student has a seizure at school):

For any non-generalized seizure:

- Time, observe, and record seizure activity
- Keep student safe if disoriented, confused or wandering
- Reassure/reorient student and allow to rest if needed after seizure
- Contact parent as noted below

For Tonic/Clonic (generalized) seizure:

- Stay calm; remove bystanders; call for clinic worker/first responder
- Keep safe; remove potentially harmful objects; don't restrain student; protect head
- Keep airway clear; turn student on side if possible and watch breathing; nothing in mouth
- Administer emergency medication as noted below

Other seizure treatments (special diet, VNS instructions, emergency medication instructions, if applicable):

____

NOTIFY PARENT IF:____

CALL 911 IF:

- ***Tonic-Clonic Seizure lasts > 5 minutes or occurs during GCPS transportation to/from school***
- ***There are multiple seizures without recovery between seizure activity***
- ***Breathing/ pulse/behavior does not return to normal after seizure***
- ***Significant injury occurs or is suspected***

School Clinic: Copy of this plan should be provided to transportation supervisor.

________________________________ ________________________________

Parent Signature **Date** **School Nurse Signature** **Date**

Revised 3/2013, 4/2016

Confidentiality must be maintained with regard to information on this form