SEIZURE
Health Management Plan
SCHOOL YEAR: _____

STUDENT NAME:	**DOB:**
SCHOOL:	**STUDENT ID:**

MOTHER:	**FATHER:**
HOME:	**HOME:**
WORK:	**WORK:**
CELL:	**CELL:**
Other Emergency Contact:	**Phone:**
Neurologist:	**Phone:** **Fax:**
Hospital Preference:	

SEIZURE Type: _____ Length: _____ Frequency: _____ Date of Last Seizure: _____

Description of seizure(s): _____
Seizure triggers/warning signs: _____

STUDENT HISTORY (including other medical conditions):

MEDICATIONS (include name, dose, frequency):

EMERGENCY MEDICATION:

Basic Seizure First Aid • Stay calm, observe, time • Keep student safe if wandering or confused • Stay with student until fully conscious • Record seizure activity • Contact parent	**Tonic-Clonic (generalized) Seizure First Aid** • Call for clinic worker and remove bystanders • Turn on side, protect head, remove potentially harmful objects, do not restrain, nothing in mouth • Keep airway open • Contact parent • Administer emergency medication as prescribed
Treatments, Considerations, Precautions:	**CALL 911 IF:** • Seizure lasts > 5 min or multiple seizures without recovery • Injury occurred or is suspected • Breathing does not return to normal • First-time seizure or student has diabetes • Emergency medication is administered

School Clinic: Copy of plan to be provided to Transportation Supervisor

_____ _____
PARENT SIGNATURE/DATE COUNTY SCHOOL NURSE SIGNATURE/DATE

Information about students and family is strictly confidential.