



# SEIZURE MANAGEMENT PLAN

SCHOOL YEAR: \_\_\_\_\_

<b>STUDENT NAME:</b>	<b>DOB:</b>
<b>SCHOOL:</b>	<b>STUDENT ID:</b>

<b>MOTHER:</b>	<b>FATHER:</b>
<b>HOME PHONE:</b>	<b>HOME PHONE:</b>
<b>WORK:</b>	<b>WORK:</b>
<b>CELL:</b>	<b>CELL:</b>
<b>EMERGENCY CONTACT:</b>	<b>PHONE:</b>

<b>NEUROLOGIST:</b>	<b>PHONE:</b>	<b>FAX:</b>
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**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**

<b>Medications (list all medications taken):</b>	<b>Dose:</b>	<b>Time:</b>
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