Western School Corporation
PLAN OF CARE – SEIZURE

Name: ____ Grade________ Age_______
Last Name First MI

School Building: ___________________________________

Parent/Guardian Name: _______________________________ Phone(H)____________

Address: ____ Phone(W)____________

Emergency Phone Contact #1: __________________ ______________ _____________
Name Relationship Phone

Emergency Phone Contact # 2: __________________ ______________ _____________
Name Relationship Phone

Physician Student Sees for Seizure: _____________________________ ____________
Phone

Other Physician: ____ ____________
Phone

ALLERGIES: ____
Food, Medication, etc.

____

____

DIET: ____
Special diet, please address any dietary restrictions or special hydration needs

____

DAILY SEIZURE MANAGEMENT PLAN (Check each that applies)

Identify the things which start a seizure:
□ Exercise □ Other ____________________________________

Comments: ____

____

ACTIVITY RESTRICTIONS: ____
Please address playground activity and sports

____

SAFETY PRECAUTIONS: ____
Protective Equipment, Helmet, etc.

____

MEDICATIONS:
(Please address side effect that need to be observed, or that might interfere with learning)

____
Name of Medication | Dosage & Frequency | Possible Side Effects

____
Name of Medication | Dosage & Frequency | Possible Side Effects

____
Name of Medication | Dosage & Frequency | Possible Side Effects

AURA (Present prior to seizure) □ Yes □ No
Please describe if present i.e. visual, auditory, olfactory ___________________________
____

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as ______________
____

Steps to take during a seizure episode:

1. Contact parent if ____
2. Seek emergency medical care – call EMS 911 immediately if student has any of the following:

   a. Absence of breathing and/or pulse

   b. Seizure of 5 minutes or greater duration

   c. Two or more consecutive (without a period of consciousness between) seizures which total 5 minutes or greater.

   d. Continued unusually pale or bluish skin/lip or noisy breathing after the seizure has stopped.

Comments/Special instructions: ____

____

____

____ ______________________________
Physician Signature Date

____ ______________________________
Parent Signature Date