Optional Student Photo

SEIZURE CARE PLAN *Side 1*

TO BE COMPLETED BY HEALTHCARE PROVIDER

EFFECTIVE DATE:	End Date:
STUDENT'S NAME:	Date of Birth:
SEIZURE HEALTHCARE PROVIDER INFORMATION Name:	
Phone #: Fax #:	
SCHOOL: / Grade	School Fax:

Seizure Triggers:

- ☐ **Missed Medication**
- ☐ **Alcohol/ Drugs**
- ☐ **Lack of Sleep**
- ☐ **Flashing Lights**
- ☐ **Emotional Stress**
- ☐ **Menstrual Cycle**
- ☐ **Physical Stress**
- ☐ **Illness with high fever**
- ☐ **Missing meals**
- ☐ **Boredom**
- ☐ **Response to Specific Food_____**
- ☐ **Other (specify) _____**

Seizure Type	How Long it Lasts	How Often	Description
☐ Absence seizures (petite-mal)			A period of unconsciousness with a blank stare or what looks like daydreaming. The person may lose muscle control and make repetitive movements.
☐ Tonic-clonic or convulsive seizures (grand-mal)			The student will lose consciousness from the start of the seizure. The muscles will stiffen (tonic phase), causing him/her to fall to the floor. The extremities will then jerk and twitch rhythmically (clonic phase). Student may froth at the mouth. Breathing may be irregular. The person will regain consciousness slowly.
☐ Mayoclonic Siezures			Consciousness and memory are not impaired. Muscle jerks may occur in parts or all of the body.

FIRST AID FOR ANY SEIZURE

- ☐ **STAY** calm, keep calm, & **BEGIN TIMING SEIZURE**
- ☐ Keep me **SAFE**- remove harmful objects, don't restrain, & protect head
- ☐ **SIDE**- turn on side if not awake, keep airway clear, don't put objects in mouth
- ☐ **STAY** until recovered from seizure
- ☐ Swipe Magnet from VNS
- ☐ Write down what happens_____
- ☐ Other_____

When to Call 911

- ☐ Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- ☐ Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- ☐ Difficulty breathing after seizure
- ☐ Serious injury occurs or suspected, seizure in water

When to call your provider first

- ☐ Change in seizure type, number or pattern
- ☐ Person does not return to usual behavior (i.e., confused for a long period)
- ☐ First time seizure that stops on its' own
- ☐ Other medical problems or pregnancy need to be checked

MEDICATION	USE	DOSE	ROUTE
☐ Diazepam (Diastat)	For seizures lasting _____minutes or longer		Rectal
☐ Midazolam	For seizures lasting _____minutes or longer		☐ Buccal ☐ Intranasal
☐			
☐			

Optional Student Photo

SEIZURE CARE PLAN *Side 2*

TO BE COMPLETED BY HEALTHCARE PROVIDER & PARENT

CARE AFTER SEIZURE

What type of help is needed? (Describe)_____

When is student able to resume normal activity?_____

SPECIAL INSTRUCTIONS

First Responders: _____

_____

Emergency Department:_____

_____

DAILY SEIZURE MEDICATIONS

Medication Name	Total Daily Amount	Amount of Tab/ Liquid	How Taken (time of each dose & how much)

OTHER INFORMATION:

Important Medical History_____

Allergies_____

☐ **YES** ☐ **NO** **Does this student have a vagal nerve stimulator (VNS) or other device?**
Please describe use: _____

☐ **YES** ☐ **NO** **Is this student allowed to participate in usual school activities including physical education?**

☐ **YES** ☐ **NO** **Does this student require any other special considerations or safety precautions?**
Please explain: _____

MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA (PRINTED)	TELEPHONE NUMBER
MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

PARENT / GUARDIAN AUTHORIZATION

I request that the medication selected and seizure protocols listed on this plan be provided to my child. I agree to defend and hold school district employees harmless from any liability for the results of the medication, or the manner in which it is administered. I agree to defend and indemnify the school district and its employees for any liability arising out of these arrangements. I will notify the school immediately if the medication is changed. I give permission for the exchange or release of health information between the medical provider listed above and the school district as part of the provision of my child's care. I understand that this medication will be destroyed at the end of the school year, per DEA federal requirements, unless I pick up the remaining medication by the last school day, as indicated on the KIBSD school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

☐ **Approved by School Nurse**

Nurse Signature _____ **Date**_____