HOWARDS GROVE SCHOOL DISTRICT-CONFIDENTIAL HEALTH INFORMATION

School Year_____ **SEIZURE HEALTH ACTION PLAN**

Student Name_____

Date of Birth_____ Grade_____ Grad Year_____

School_____ Teacher/HR_____

PARENT/GUARDIAN EMERGENCY CONTACT INFORMATION:

Please provide phone numbers in order of where we can best reach you during the school day in case of emergency

Phone 1. _____ H/C/W Name/ Relationship _____

Phone 2. _____ H/C/W Name/ Relationship _____

Phone 3. _____ H/C/W Name/ Relationship _____

Phone 4. _____ H/C/W Name/ Relationship _____

Address for Health Plan updates:_____

Email for Health Plan updates: _____

Physician student sees for Seizures_____ Phone Number_____

SEIZURE INFORMATION

SEIZURE TYPE	LENGTH	FREQUENCY	DESCRIPTION

Receiving Treatment? Yes____ No____ If febrile seizures, temperature at which they occur _____ F

Seizure History (note date of last seizure):_____

_____

Significant Medical History:_____

_____

Seizure Triggers or Warning Signs_____

_____

Students Reaction During Seizure: _____

_____

Likelihood and Frequency of Seizures During School Hours:_____

_____

Please specify any special considerations or concerns related to your child's seizures while at school, i.e., dietary, educational, behavior, recess, physical education, classroom precautions, school activities, sports, trips, etc.: (Note: Activity restrictions specified by physician need to be in writing and signed by the doctor.)

_____

_____

_____

Seizure Medication Given at **Home** (name, dose, frequency):_____

_____

(SEE NEXT PAGE FOR EMERGENCY MEDICATION TO BE GIVEN AT SCHOOL)

NOTE: Parents are responsible for providing medication to be given during school. A Medication Authorization Form needs to be filled out and signed by a health care provider and parent annually. Medications must be in the original labeled container.

PLEASE COMPLETE & SIGN NEXT PAGE

STUDENT NAME:_____ DATE OF BIRTH_____

EMERGENCY ACTION PLAN FOR STAFF

NOTE: Care during a seizure is intended to keep the student safe, and when necessary, to stop a seizure. Most seizures stop on their own within 3 minutes.

Care and Comfort

- Stay calm and note the time that seizure began on the Seizure Flowsheet
- **Call for "Medical Support" if you do not feel comfortable responding to a seizure**
- Have someone retrieve the student's emergency seizure medication (if at school). Don't leave child alone
- Do not try to stop or restrict the movements. Keep the child safe
- Clear the area around the student of any hard, sharp or hot objects
- Place something soft and flat behind the student's head
- Do not put anything in the mouth or between the teeth
- For a convulsive (tonic-clonic) seizure, gently roll the student onto one side until he/she is awake and watch breathing closely
- Administer Emergency Medication as prescribed
- Stay with the student until the seizure is over and they can respond when you talk with them.
- Allow them to rest or go home if too fatigued to work successfully in the classroom
- Record what the student did during the seizure, how she/he acted before and after the seizure, whether one side or part of the body was more affected than another during the seizure, and how long the seizure lasted on the seizure flow sheet.
- Notify parent/guardian and notify school nurse
- Complete an Incident Report and Medical Support Report (if called)

Student has seizure emergency medication Yes _____ No _____ Location _____
Medication (Name/Dose/Route):

_____

Special Instructions

_____

CALL 911 IMMEDIATELY:

- **If seizures are convulsive (tonic-clonic) seizure lasts longer than 5 minutes**
- **If DiaStat or other emergency medication was administered and seizure continues**
- **If seizures are consecutive (occurring one after the other)**
- **If student has a first time seizure**
- **If student appears bluish or gray after the seizure ends or has difficulty breathing**
- **If student was injured during the seizure or the seizure occurred in water**
- **If student might be pregnant or has Diabetes**

Memo of Understanding:

- It is understood that a parent will complete and sign a Seizure Health Plan annually.
- It is understood that a parent will provide emergency medications needed at school.
- It is the responsibility of the parent to notify the school district of any changes in the health plan.

This plan and medication will be used in case of emergency and accompany student off school property. This information may be shared with the classroom teacher(s), administrators, aides, bus driver, and other appropriate school personnel with a need to know.

Parent/Guardian Signature: _____ Date _____
School Nurse: _____ _____ Date _____
Building Administrator:_____ _____ Date _____
Physician Signature (if applicable): _____ Date _____