

SEIZURE HISTORY/CARE PLAN

Child's Name: _____ Birth date: _____ Grade: _____

	Name	Home#	Work#	Cell#
Parent/Guardian				
Parent/Guardian				
Emergency				
Other				
Other				

Treating Physician	Phone#

Date of Diagnosis _____ Date of Last Seizure _____

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Child's response after a seizure: _____

Any restrictions/limitations at school: _____

Medication Protocol During School Hours (Daily Seizure Meds and Emergency Meds) *			
Emerg. Med. ✓	Daily Medication	Dosage & Time of Day Taken	Special Instructions & Common Side Effects

***Any use of medication at school requires HCP order (Form #SSS-H-08)**

Does child have a **Vagal Nerve Stimulator**? YES NO
 YES, describe use _____

Seizure Treatment Protocol (Check all that apply and clarify)

- Contact School Nurse at _____
- Notify parent/emergency contact
- Administer Medications as described above
- Call 911 if seizure lasts longer than _____ minutes
- Other _____
- Other _____
- Evaluate for signs of injury

After Seizure

- Stay with student Other _____
- Allow student to rest _____

Seizure Care
* Stay calm
* Stay with student
* Lower student to the floor
* Provide privacy
* Document time and length of seizure
* DO NOT RESTRAIN
* DO NOT PUT ANYTHING IN MOUTH

NCSD reserves the right to call 911 at anytime.

Physician Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____