NATRONA COUNTY SCHOOLS

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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:_____