Pulaski County Schools
Seizure Disorder Health Care and Emergency Plan

Student's Name: _____Date of Birth: _____
Parent/Guardian: _____Phone: _____Cell: _____
Treating Physician: _____Phone: _____Fax: _____

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____
Student's response after a seizure:_____

Basic Seizure First Aid	**A Seizure is generally considered an emergency when:**
• Stay calm & track time • Keep child safe • Do not restrain • Do not put anything in mouth • Stay with child until fully conscious • Record seizure in log **For tonic-clonic seizure** • Protect head • Keep airway open/watch breathing • Turn child on side	• Convulsive (tonic-clonic) seizure lasts longer than 5 minutes • Student has repeated seizures without regaining consciousness • Student is injured or has diabetes • Student has a first-time seizure • Student has breathing difficulties • Student has a seizure in water • Student is pregnant

Emergency Response:

Seizure Emergency Protocol
(Check all that apply and clarify below)
☐ Contact school nurse at _____
☐ Call 911 for transport to _____
☐ Notify parent or emergency contact _____
☐ Administer emergency medications as indicated below
☐ Notify doctor _____
☐ Other _____
_

Treatment Protocol during School Hours (include **daily** and emergency medications**)**

Emergency. Med. ☐	**Medication**	**Dose/Time/Route**	**Common Side Effects & Special Instructions**

Does student have a Vagus Nerve Stimulator? ☐ Yes ☐ No If Yes, describe magnet use: _____
_____

Special Considerations and Precautions (regarding school activities, sports, field trips, etc.)
Describe any special considerations or precaution: _____

Physician Signature: _____Date: _____
Parent/Guardian Signature: _____Date_____
Revised: May 11, 2016

Student's Name: _____Date of Birth: _____

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Treating Physician: _____

How many times has your child been seen in the emergency room for this condition in the last year? _____

Age of onset of Seizures: _____Date of last Seizure: _____Time/length of Seizure: _____

Please list known triggers for seizure activity: _____
_____
_____

Please list any warning signs and/or a behavioral change that may indicate a seizure is about to occur: _____
_____

Does your student have any special diet? _____

Any other health information you would like to share about seizure disorder: _____
_____
_____

Parent/Guardian Consent: I have reviewed and approve this health and emergency care plan for my child. I authorize unlicensed trained personnel of Pulaski County Schools to administer medication to my child as prescribed by physician and to provide emergency treatment as written in the above plan in the absence of the school nurse. I understand that I am responsible for supplying any medication, supplies or equipment needed by my child to manage his/her seizure disorder at school. I authorize the school to contact my child's physician regarding my child's health condition. This health care plan can be updated at any time my child's circumstances require modifications in treatment, but will be reviewed annually. I agree to notify the school if a change occurs in my child's health plan. I also consent to the release of the information contained in this care plan to Pulaski County Public School personnel who care for my child and who may need to know this information to maintain my child's health and safety.

Parent/Guardian Signature: _____Date: _____

School Nurse Signature: _____Date: _____

The following staff members have been trained to administer medication and assist with this student's care at school in the absence of the school nurse.

1.
2.
3.
4.

Revised: May 11, 2016