



SEIZURE
Health Management Plan
 SCHOOL YEAR: _____

STUDENT NAME:	DOB:
SCHOOL:	STUDENT ID:

Parent/Guardian:	Parent/Guardian:
HOME:	HOME:
WORK:	WORK:
CELL:	CELL:
Other Emergency Contact:	Phone:
Neurologist:	Phone: Fax:
Hospital Preference:	

SEIZURE Type: _____ **Length:** _____ **Frequency:** _____ **Date of Last Seizure:** _____

Description of seizure(s): _____
Seizure triggers/warning signs: _____

STUDENT HISTORY (including other medical conditions):

MEDICATIONS (include name, dose, frequency):

EMERGENCY MEDICATION:

Basic Seizure First Aid <ul style="list-style-type: none"> Stay calm, observe, time Keep student safe if wandering or confused Stay with student until fully conscious Record seizure activity Contact parent 	Tonic-Clonic (generalized) Seizure First Aid <ul style="list-style-type: none"> Call for clinic worker and remove bystanders Turn on side, protect head, remove potentially harmful objects, do not restrain, nothing in mouth Keep airway open Contact parent Administer emergency medication as prescribed
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Treatments, Considerations, Precautions: _____ _____ _____ _____	CALL 911 IF: <ul style="list-style-type: none"> Seizure lasts > 5 min or multiple seizures without recovery Injury occurred or is suspected Breathing does not return to normal First-time seizure or student has diabetes Emergency medication is administered
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School Clinic: Copy of plan to be provided to Transportation Supervisor

 PARENT SIGNATURE/DATE

 COUNTY SCHOOL NURSE SIGNATURE/DATE

Information about students and family is strictly confidential.