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| **Student’s Name:** |  | **Grade:** |  | **Student’s Date of Birth:** |  |
| **School Name:** |  | **School Address:** |  |

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| **THIS PERSON HAS POTENTIALLY LIFE-THREATENING SEIZURES** | **FIRST AID FOR SEIZURES (CROSS OUT ANY THAT DO NOT APPLY)** |
| Photo | **Seizure Information:** | * Keep Calm. Stay with student.
* Do not restrain the student
* Protect student from injury:
	+ Move hazardous objects out of way
	+ Lower student to the floor (if possible)
	+ Loosen anything tight from around the neck
	+ Do not put anything in the student’s mouth
* Afterwards, gently roll the student on their side
* Call Emergency Contact

**CALL 9-1-1 if seizure lasts more than 5 minutes, if the student has several seizures in a row, or if confusion lasts for more than 20 minutes after the seizure.** |
| Type(s) of Seizure |       |
| Frequency |       |
| Date of last seizure: |       |
| **Emergency Medication Information:** |
| **The student is taking medications for seizures:** |
| [ ]  YES [ ]  NO |
| Medication Name: |       |
| Location: |       |
| Dose: |       |
| Length of time on meds |       |
| \***This Careplan is NOT suitable for students with seizure rescue medications**. If rescue medications are needed, please contact the nursing support services |

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| **THE STUDENT’S SEIZURES USUALLY PRESENT LIKE:** | **EMERGENCY CONTACT INFO:** |
| Warning signs before a seizure:     What happens during a seizure:      | **Name** | **Relationship** | **Cell Phone** | **Other Phone** |
|       |       |       |       |
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*The undersigned parent/guardian authorizes any adult to provide the first aid management outlined above to the above-named person in the event of a seizure, as described above. This protocol has been recommended by the student’s Doctor/Nurse Practitioner. The plan will be shared with appropriate facility/school personnel to assist in responding in an Emergency. It is the parent/guardian's responsibility to advise the school about any changes to this plan.*

Parent/Guardian Date Doctor/Nurse Practitioner Date