SUSSEX COUNTY PUBLIC SCHOOLS

SEIZURE HEALTH CARE PLAN

Please return this seizure health care plan to your child's school nurse.

Student: ________________________________ **Date of Birth:** ______________ **School Year:** _______

School: __________________________________**Homeroom Teacher:** ________ **Grade/Team:** _____

EMERGENCY CONTACTS

Parent/Guardian/Contact	Relationship	Phone Number	Alt Phone Number
Seizure Healthcare Provider:		***Phone Number:***	

SEIZURE HISTORY:

____

____

Has student ever been hospitalized for seizures? □ No □ Yes
If yes, length of hospitalization and complications: ____________________________________

SEIZURE INFORMATION:

Seizure Type	Length	Frequency	Description

Seizure Triggers or warning signs: ____

____

EMERGENCY PLAN:

Seizure emergency for this student is:

□ Tonic-clonic seizure lasting longer than 5 minutes
□ Difficulty breathing or change in color
□ Cluster seizures (_____ number in _____ minutes)
□ Additional Chronic Health Condition: ____________________________________
□ Other: ____

Emergency Actions *(Check all that apply):*
- □ Contact Clinic Staff
- □ Call 911 for transport to ________________________________
- □ Notify parent or emergency contact
- □ Administer emergency medications indicated below
- □ Notify healthcare provider
- □ Other: ________________________________

BASIC SEIZURE FIRST AID CARE:
- □ Stay calm and track time
- □ Keep student safe; protect head
- □ Do not restrain
- □ Do not put anything in mouth
- □ Stay with student until fully conscious
- □ Documentation on *Student Seizure Record*

After seizure, does student need to leave classroom? □ No □ Yes
If yes, where: ______________ Length of time: ____ Then, ______________

DAILY MEDICATIONS *(including daily and emergency medications):*

Medication Name	*Dosage (amount)/Time*	*When To Use*	*Given at School*
			□ YES □NO
			□ YES □ NO
			□ YES □ NO
			□ YES □ NO
			□ YES □ NO

Does student have a Vagal Nerve Stimulator □ No □ Yes
If yes, describe magnet use: ________________________________

SPECIAL CONSIDERATIONS AND PRECAUTIONS (including school activities, sports and trips):

____
____
____
____
____

►Physician's Signature◄ ________________________________ *Date:* ____________

PRINT Physician's Name: ______________________Telephone Number: ______________________

I, this child's parent/guardian, authorize disclosure of information to be shared with pertinent school staff so that my child's medical needs may be served while in attendance in the Sussex County School District. This authorization expires as of the last day of the school year.

►Parent/Guardian's Signature◄ ________________________________ *Date:* __________