



WASHINGTON ELEMENTARY SCHOOL EMERGENCY HEALTH CARE PLAN SEIZURE DISORDER / EPILEPSY

Seizures (also known as epileptic seizures and if recurrent, epilepsy) are thought to result from disturbances in cells of the brain that cause them to give off abnormal, recurrent, uncontrolled electrical discharges.

Student Name:	School:	Grade:
Contacts:		Phone:

1. **OPEN AND MAINTAIN AIRWAY.**

2. **KEEP CALM! Provide a safe environment.** Lower student safely to the ground, move any furniture that may be in the way. Call the office stating...
"I have an emergency, _____ is having a seizure."
 The office will dial 911 after 5-7 minutes or if student is not breathing.

3. **You cannot stop a seizure once it has started. DO NOT** restrain the student. **DO NOT** try to revive the student. Let the seizure run its course. Keep the student safe.

4. **Try to prevent the student from striking his/her head or body** against any hard, sharp or hot object, **BUT DO NOT** interfere with student's movements.

5. **Do NOT** put anything in student's mouth. **DO NOT** force anything between student's teeth!

6. **Place the student on his/her side if possible.** This will prevent aspiration.

7. **Protect the student's head:** Place something soft, such as a rolled-up coat, beneath the student's head.

8. **Observe the seizure.** A seizure report should be filled out to communicate the observations of the seizure to medical personnel.

9. **Notify parents IMMEDIATELY.**

10. **Call School Nurse @ 851-6466**

SPECIAL INSTRUCTIONS: _____

I hereby request and authorize school personnel to implement the above plan if needed. Authorization includes permission for school personnel and Physician/health care provider to contact each other if needed.

Parent Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____



**Washington Elementary School
Physician Order/ Care Plan for Seizures**

Student's Name: _____
School: _____ **Grade:** _____ **Date of Birth:** _____
Gender: _____ **Teacher Name:** _____ **Room#:** _____

Physician Section:

List measures school personnel are to take when a seizure occurs at school:

Limitations:

Emergency Medical Services should be called when:

Additional Comments: _____

Medications to be given at school:

Name of Medication	Dose	Route	Time	Possible Side Effects

Physician Signature: _____ Date: _____

Physician Printed Name: _____

Telephone: _____ Fax: _____

Parent Signature: _____ Date: _____



Washington Elementary School

Student SEIZURE History

Date: _____
Effective Date: _____

Student Name _____	DOB/AGE _____	Today's Date _____
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Parent Names: _____ Phone #: _____ home _____ work _____ cell _____

Emergency Contact: _____ Phone #: _____ home _____ work _____ cell _____

Local Doctor's Name: _____ Phone #: _____ work _____ other _____

Neurologist's Name: _____ Phone #: _____ work _____ other _____

Date of last doctor visit: _____ Reason for visit: _____

Date of next doctor visit: _____ Reason for visit: _____

Age at 1st seizure: _____ Fever related? _____ How often did they occur? _____ How long did they last? _____

Name/Kind of Seizure: _____

Status Epilepticus ever? _____

Current Medications

Name _____ Dose _____ Time taken _____

Name _____ Dose _____ Time taken _____

Typical Seizure Pattern for this student

Warning signs _____

Usually looks like _____

After it's over _____

How often do they occur? _____ Usually lasts how long? _____

Special things that you do for your child during/after a seizure _____

When do you call 911? _____ Date of last 911 call _____

Take your child to ER? _____ Date of last ER visit _____

Other information: _____

Aura or indication before seizure to alert you that seizure is about to occur? Yes No

If yes, what? _____

Please check (✓) the following boxes to indicated what activity you usually see with your child's seizures:							
<i>Body involved:</i>	<input type="checkbox"/> upper	<input type="checkbox"/> lower	<input type="checkbox"/> whole	<input type="checkbox"/> right arm	<input type="checkbox"/> right leg	<input type="checkbox"/> left arm	<input type="checkbox"/> left leg
<i>Extremity involved:</i>	<input type="checkbox"/> straight	<input type="checkbox"/> bent	<input type="checkbox"/> rigid	<input type="checkbox"/> limp	<input type="checkbox"/> jerking	<input type="checkbox"/> trembling	<input type="checkbox"/> twitching
<i>Face involved:</i>	<input type="checkbox"/> right	<input type="checkbox"/> left	<input type="checkbox"/> rigid	<i>Head turns:</i>	<input type="checkbox"/> right	<input type="checkbox"/> left	<input type="checkbox"/> down <input type="checkbox"/> back
<i>Mouth involved:</i>	<input type="checkbox"/> open	<input type="checkbox"/> closed	<input type="checkbox"/> drooling	<input type="checkbox"/> vomiting	<input type="checkbox"/> grimacing	<input type="checkbox"/> twitching	
<i>Eyes involved:</i>	<input type="checkbox"/> open	<input type="checkbox"/> closed	<input type="checkbox"/> fluttering	<input type="checkbox"/> rolled back			
<i>Breathing involved:</i>	<input type="checkbox"/> slows down	<input type="checkbox"/> stops (how long? _____)	<input type="checkbox"/> labored	<input type="checkbox"/> quiet	<input type="checkbox"/> wet/raspy	<input type="checkbox"/> sounds	
<i>Skin color:</i>	<input type="checkbox"/> pale	<input type="checkbox"/> gray	<input type="checkbox"/> blue	<input type="checkbox"/> red/flushed			
<i>Alertness:</i>	<input type="checkbox"/> unconscious			<input type="checkbox"/> semi-conscious		<input type="checkbox"/> fully awake	
<i>Communication:</i>	<input type="checkbox"/> cries out	<input type="checkbox"/> talks coherently/responsively	<input type="checkbox"/> can't talk		<input type="checkbox"/> nods head		
<i>Bladder control:</i>	<input type="checkbox"/> wets self <input type="checkbox"/> bowel control: soils self						
<i>Recovery:</i>	<input type="checkbox"/> drowsy	<input type="checkbox"/> sleeps (how long? _____)	<input type="checkbox"/> confused	<input type="checkbox"/> mostly alert	<input type="checkbox"/> fully alert		



Washington Elementary School
Individual Health Care Plan
SEIZURES/EPILEPSY

Date: _____
 Effective Date: _____

Student Name	DOB/AGE	Today's Date
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Call 911 immediately? Yes No
 Call 911 only if seizure lasts longer than: 5 minutes 4 minutes 3 minutes 2 minutes
 Contact parent immediately and request they come to the school.

Note time, duration and description of seizure.

WHAT TO DO/NOT DO DURING A SEIZURE:

DO NOT:

- Restrain the student.
- Stimulate by rubbing any part of the student's body.
- Try to force mouth open or put anything into the mouth.
- Move the student during the stiff and shaking part of the seizure.
- Be alarmed by movements and sounds coming from the student.

DO:

- Stay calm, *do not panic!*
- Reassure other students that this is "normal" for this student.
- Gently move the student to the floor when possible.
- Protect the student from injuring him/herself
 - Move desk, books, other objects away from the student.
- Turn the student on his/her side if on the floor.
 - Make sure the airway is open – may have to tilt head backwards slightly.

Parent Names: _____ Phone #: _____ home _____ work _____ cell

Emergency Contacts: _____ Phone #: _____ home _____ work _____ cell

Local Doctor's Name: _____ Phone #: _____ work _____ other

<i>I have read the above and agree to have the information shared with the following people:</i>		<input type="checkbox"/> Principal <input type="checkbox"/> Teaching staff <input type="checkbox"/> PE teacher <input type="checkbox"/> Office Staff <input type="checkbox"/> Instructional Assistant <input type="checkbox"/> Playground Supervisor <input type="checkbox"/> Bus Driver bus# _____ <input type="checkbox"/> Counselor <input type="checkbox"/> Psychologist <input type="checkbox"/> Nurse <input type="checkbox"/> Other _____
_____ Parent's Signature	_____ Date	
_____ Nurse's Signature	_____ Date	

**TOWNSHIP OF UNION BOARD OF EDUCATION
UNION, NEW JERSEY**

Pupil's Name _____ School _____

Address _____ Teacher _____

Telephone No. _____ Grade _____

Description of medication provided by physician _____

Diagnosis: _____

School nurse is instructed to administer _____ in

the following manner _____

Medication to be administered from _____ to _____

Consideration for Field Trips:

The above named student may skip the dose of prescribed medication on a field day trip.

The above named student may take the prescribed medication upon returning to school from a field trip.

Date _____
(Physician's Signature & Stamp Required)

The school nurse is requested to administer to _____
(Child's Name)

the medication prescribed by the above-named physician.

Signature of Parent/Guardian _____

The completion of this form is the responsibility of the parent. Upon its completion, it is to be given to the school nurse who will give the medication prescribed. This form will be filed in the office of the school nurse.

**MEDICATION MUST BE BROUGHT TO SCHOOL BY PARENT IN THE
PRESCRIPTION CONTAINER AND HANDED TO THE NURSE.**