



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 have read the above and agree to have the
Information shared with the following people:*

Parent's Signature Date

Nurse's Signature Date

- Principal
- Teaching staff
- PE teacher
- Office Staff
- Instructional Assistant
- Playground Supervisor
- Bus Driver bus# _____
- Counselor
- Psychologist
- Nurse
- Other _____



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:							
Body involved:	<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
Extremity involved:	<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
Face involved:	<input type="checkbox"/> right	<input type="checkbox"/> left	<input type="checkbox"/> rigid	Head turns:	<input type="checkbox"/> right	<input type="checkbox"/> left	<input type="checkbox"/> down <input type="checkbox"/> back
Mouth involved:	<input type="checkbox"/> open	<input type="checkbox"/> closed	<input type="checkbox"/> drooling	<input type="checkbox"/> vomiting	<input type="checkbox"/> grimacing	<input type="checkbox"/> twitching	
Eyes involved:	<input type="checkbox"/> open	<input type="checkbox"/> closed	<input type="checkbox"/> fluttering	<input type="checkbox"/> rolled back			
Breathing involved:	<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	
Skin color:	<input type="checkbox"/> pale	<input type="checkbox"/> gray	<input type="checkbox"/> blue	<input type="checkbox"/> red/flushed			
Alertness:	<input type="checkbox"/> unconscious		<input type="checkbox"/> semi-conscious		<input type="checkbox"/> fully awake		
Communication:	<input type="checkbox"/> cries out	<input type="checkbox"/> talks coherently/responsively	<input type="checkbox"/> can't talk		<input type="checkbox"/> nods head		
Bladder control:	<input type="checkbox"/> wets self		<input type="checkbox"/> bowel control: soils self				
Recovery:	<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
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 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:** _____