**20\_\_-20\_\_ EASD INDIVIDUALIZED HEALTH CARE PLAN:**

Student photo here

**SEIZURE**

Student \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grd \_\_\_\_\_\_ School \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School records indicate your child has a seizure disorder. The school is requesting the following information so we can better assist your child should a seizure occur at school.**

Please answer the following questions and return to school for new school year:

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| Seizure type : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Describe the seizures : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Average length of time seizure lasts: \_\_\_\_\_\_\_\_\_\_  How often seizures occur :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Describe student’s behavior following a seizure : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    What will trigger a seizure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List any warning signs before the seizure : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any Restrictions relating to school :  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Basic Seizure First Aid**  • Stay calm & track time  • Keep child safe  • Do not restrain  • Do not put anything in mouth  • Stay with child until fully conscious  • Record seizure in log  **For seizure:**  • Protect head  • Keep airway open/watch breathing  • Turn child on side  **A seizure is generally considered an emergency when:**  • \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ seizure lasts longer than 5 minutes  • Student has repeated seizures without regaining consciousness  • Student is injured or has diabetes  • Student has a first-time seizure  • Student has breathing difficulties  • Student has a seizure in water  **Call 911. Call Parent. Administer meds per protocol below.**  *Copyright 2008 Epilepsy Foundation of America, Inc* |

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| **Please list any medications your child receives:**    Name of medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose/Time given \_\_\_\_\_\_\_\_\_\_\_\_\_\_    Name of medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose/Time given \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Additional Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospital/Clinic** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Signature Date**

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**Parent Signature Date Emergency Contact phone#**