**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#**