Lee County Schools / Student Health Services

Seizure Care Plan

Please bring or mail this health care plan to the school or send to the secure FAX at 229-903-3568.

Student's Name:____Date of Birth:_____________ School Year____________

Treating Physician:__________________________________ Phone: ____

Significant medical history:____

SEIZURE INFORMATION:

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:____

Student's reaction to seizure:____

BASIC FIRST AID: CARE & COMFORT: **(Please describe basic first aid procedures)**

Does student need to leave the classroom after a seizure? YES NO

If YES, describe process for returning student to classroom

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 tonic-clonic (grand mal) seizure:
- ✓ Protect head
- ✓ Keep airway open/watch breathing
- ✓ Turn child on side

EMERGENCY RESPONSE:

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol: *(Check all that apply and clarify below)*

- ☐ Contact school nurse at ______________________________________
- ☐ Call 911 for transport to ______________________________________
- ☐ Notify parent or emergency contact
- ☐ Notify doctor
- ☐ Administer emergency medications as indicated below
- ☐ Other____

A Seizure is generally considered an Emergency when:
- ✓ A convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ✓ Student has repeated seizures without regaining consciousness
- ✓ Student has a first time seizure
- ✓ Student is injured or has diabetes
- ✓ Student has breathing difficulties
- ✓ Student has a seizure in water
- ✓ Person is pregnant

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Emergency/Rescue Medication

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Does student have a **Vagus Nerve Stimulator (VNS)**? YES NO

If YES, Describe magnet use____

SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: ***(regarding school activities, sports, trips, etc.)***

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Physician Signature:____**Date:**_________________________

Parent Signature:____**Date:**_________________________