

Seizure Care Plan for Desoto County Schools

Student's Name: _____ Grade: ____ Teacher: _____

Parent/Guardian's name: _____ Daytime phone: _____

Parent/Guardian's name: _____ Daytime phone: _____

Other emergency contact: _____ Phone: _____

Treating Physician: _____ Phone: _____

Seizure triggers or warning signs: _____

Basic First Aid for Seizures:

- *Assist the student to the floor, if needed*
- *DO NOT put anything in the mouth*
- *DO NOT restrain*
- *Clear area to protect student from injury (place something soft under their head)*
- *Keep airway open/ watch breathing*
- *Turn student on their side*
- *Start CPR if necessary*
- *Start a written record of the seizure behavior and treatment, including length of seizure activity.*
- *Give emergency medication as ordered:* _____

- *Notify parents*

Call 911 if:

- *Seizure activity is different from "usual" seizure activity*
- *Student's breathing is affected*
- *Seizure last longer than 5 minutes*
- *Student fails to regain consciousness after seizure activity has stopped.*
- *Student's usual seizure activity includes:* _____

- *If the seizure activity last longer than ____ minutes, 911 should be called.
(Note: 911 will be called by school staff for any seizure activity lasting longer than 5 minutes unless otherwise instructed by doctor.)*

After the seizure:

- *Permit the student to rest*
- *Continue to document the episode*
- *Monitor for second episode*
- *Monitor for confusion or lack of consciousness.*

Other special instructions for seizures: _____

Does the student have a Vagus Nerve Stimulator? ___ Yes ___ NO

If yes, instructions for use: _____

Special considerations and precautions regarding school activities, sports, field trips, etc. _____

If I cannot be reached by phone and my child does not respond to the treatment, I give my permission for school staff to call the physician listed above and to follow his/her instructions. If the physician orders hospitalization or my child is exhibiting symptoms of a medical emergency, my child will be transported to the nearest hospital. I also understand that school staff can and will be informed of my child's health concerns in order to provide safe, appropriate care.

Parent/Guardian Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

List of current medications:

1. _____ Dose _____ Times given _____

2. _____ Dose _____ Times given _____

3. _____ Dose _____ Times given _____