

DeKalb County Eastern CSD **SEIZURE CARE PLAN**

Student name _____ Teacher _____
 Parent/Guardian _____ Phone #1 _____
 Address _____ Phone #2 _____
 Parent/Guardian _____ Phone #1 _____
 Address _____ Phone #2 _____

Physician caring for seizures _____ Phone _____
 Family physician (if different) _____ Phone _____
 Date of onset of seizures _____ Frequency of seizures _____

Type of seizures: (student may experience some or all of the listed symptoms during a specific seizure)

___ Absence	* Staring * Eye blinking	* Loss of awareness * Other:
___ Simple Partial	* Remains conscious * Distorted sense of smell, hearing, sight.	* Involuntary rhythmic jerking, twitching on one side.
___ Complex Partial	* Confused * Not fully responsive/unresponsive	* May appear fearful * Purposeless, repetitive movements * Other:
___ Generalized tonic-clonic	* Convulsions * Stiffening * Breathing may be shallow * Lips or skin may have bluish color	* Unconsciousness * Confusion, weariness, or belligerence when seizure ends. * Other:

Seizures usually last _____ minutes. Student returns to baseline in _____ minutes.

Allergies (food, medication, etc.)

No Yes If yes, please explain _____

Dietary Restrictions _____

Identify What Things Start A Seizure

- Exercise Other: _____
 Stress Comments: _____
 Heat _____
 Fatigue _____
 No known causes at this time. _____

Activity Restrictions

- Playground Sports Activities Swimming
- Other: _____ Comments: _____

Safety Precautions (helmet, etc.) _____

Medications (Please include any side effects the staff needs to observe for, or that might interfere with learning)

(Name of medication)	(Dosage/Frequency)	(Possible Side Effects)

See attached for a list of additional medication(s).

Aura (Prior to seizure) No Yes – please explain below (hears, sees, smells something, etc.)

Emergency Plan

Emergency action is necessary when the student has symptoms such as:

Follow this action plan for a seizure episode:

Contact parent if: _____

Hospital Preference: _____ Insurance company: _____

Emergency Medical Care – call 911 immediately if the student has any of the following:

- Absence of breathing and/or pulse.
- Seizure of 5 minutes or greater duration.
- Two or more seizures, without a period of consciousness between which last 5 minutes or greater.
- Continued unusually pale or bluish lips/skin or noisy breathing after the seizure has stopped.

Special Instructions: _____

Physician Signature _____ **Date:** _____

Physician Printed Name: _____

I have read, understand, and agree with the above treatment plan. I will notify the school nurse in writing if there are any changes in this plan. The school nurse may communicate with the above physician via telephone and/or fax.

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