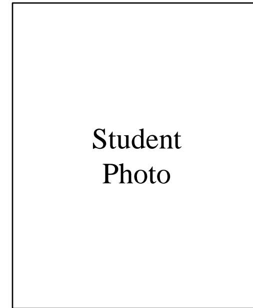
Seizure Emergency Care Plan


Student Photo

Student: ______________________________

Grade: ____ DOB: __________School Year: __________

Mother: ______________________________

Best phone number: ______________________________

Father: ______________________________

Best phone number: ______________________________

Emergency Contact: __________________ Relationship: __________ Phone number: __________

Seizure Information

Seizure Type/Name: ______________________________ How Often: __________

What Happens: ______________________________ How Long Does It Lasts: __________

SEIZURE TRIGGERS (check all that apply)**:**

- ☐ Missed Medicine
- ☐ Emotional Stress
- ☐ Menstrual Cycle
- ☐ Missing meals
- ☐ Lack of Sleep
- ☐ Physical Stress
- ☐ Flashing Lights
- ☐ Illness with high fever
- ☐ Specific food Specify: __________________
- ☐ Other Specify: __________________

SYMPTOMS that signal an oncoming seizure (check all that apply):

- ☐ Headache
- ☐ Staring Spells
- ☐ Confusion
- ☐ Dizziness
- ☐ Change in Vision/Aura
- ☐ Sudden Feeling of Fear or Anxiety
- ☐ Other Specify: __________________

Does student need to leave the classroom after a seizure? ☐Yes ☐No

If yes, describe process for returning student to classroom: __________________

POST SEIZURE RECOVERY typical behaviors after seizure (check all that apply):

- ☐ Headache
- ☐ Drowsiness/Sleep
- ☐ Nausea
- ☐ Aggression
- ☐ Confusion/Wandering
- ☐ Blank Staring
- ☐ Other Specify: __________________

Seizure Medicine (*To be Completed by a Recognized Medical Authority**)

Name of Medication	Dosage Prescribed	Administration Time/Frequency

** Physician, Physician Assistant, or Nurse Practitioner licensed to practice in the State of California*

Date: __________

Print Physician's Name: __________________

Office Stamp

Physician's Signature: __________________

Parent/Guardian Signature: ______________________________ Date: __________

This plan is in effect for only one school year.

Seizure Emergency Care Plan

All Emergency Care Plans need to be updated annually. The information given assists the district nurse in developing an Individual Healthcare Plan for each student.

1. **Medical alert jewelry worn:** ☐Yes ☐No **IEP:** ☐Yes ☐No **504 Plan**: ☐Yes ☐No
2. **Age at onset of seizures?** ____________ **When was the student's last seizure?** _________________
3. **Describe what a seizure looks like** (stares into space, body stiffens, loses bladder control, etc.):
   ____
   ____
4. **Has student ever had a seizure that lasted longer than 5 minutes?** ☐Yes ☐No
5. **Describe the student's understanding of their seizure disorder**:
   ☐ None ☐ Limited ☐ Basic ☐ Knowledgeable
6. **Special considerations and precautions** (check all that apply and describe any actions that should be taken):

   ☐ General health ____
   ☐ P.E. & sports ____
   ☐ Learning ____
   ☐ Recess ____

Image adapted with permission from the Epilepsy Foundation of America

Basic Seizure First Aid	A seizure is generally considered an emergency when:
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 chronic seizure:** Protect head Keep airway open/watch breathing Turn child on side	Convulsive seizure lasts longer than 5 minutes Student has repeated seizures without regaining consciousness Student is injured or has diabetes Student has a seizure for the first time Student has breathing difficulties Student has a seizure in water