WEBSTER SCHOOL DISTRICT

HEALTH CARE PLAN FOR SEIZURE MANAGEMENT

Student: _____ Date of Birth _____ / _____ / _____

Teacher: _____ Grade: _____ School Year: _____

Mother/Guardian's Name: _____

Home Address: _____ City / ZIP: _____

Home Phone: (____) _____ Cell phone: (____) _____

Work Phone: (____) _____ Work Hours: _____

Father/Guardian's Name: _____

Home Address: _____ City / ZIP: _____

Home Phone: (____) _____ Cell phone: (____) _____ Pager: (____) _____

Work Phone: (____) _____ Work Hours: _____

Primary Care Physician: _____ Phone: _____ Hospital: _____

Neurologist: _____ Phone: _____ Nurse: _____

Seizure Description

Seizure Type: _____

Description of Seizure: _____

_____

Possible Triggers: _____

Frequency of seizures: _____ per _____. Last date of seizure was _____

Average Length of Seizure Activity: _____ Usual time of day of Seizure Activity: _____

Average time until Student can return to Regular Activities: _____

Student's reaction to Seizure: _____

Medication

Name of Daily Medication	Dose	Route	Time of Day	Start Date	Stop Date
1.					
2.					
3.					

Name of Emergency Medication	Dose	Route	Reason to be given
1.			

Student's Name: _____

First Aid

1. Keep calm and reassure other people who may be nearby.
2. Don't hold the person down or try to stop his movements.
3. Time the length of the seizure with your watch.
4. Clear the area around the person of anything hard or sharp.
5. Loosen ties or anything around the neck that may make breathing difficult.
6. Put something flat and soft, like a folded jacket, under the head.
7. Turn him or her gently onto one side. This will help keep the airway clear. Do not try to force the mouth open with any hard implement or with fingers. **It is not true that a person having a seizure can swallow his tongue.** Efforts to hold the tongue down can injure teeth or jaw.
8. Don't attempt artificial respiration except in the unlikely event that a person does not start breathing again after the seizure has stopped.
9. Stay with the person until the seizure ends naturally.
10. Be friendly and reassuring as consciousness returns.
11. Offer to call a taxi, friend or relative to help the person get home if he seems confused or unable to get home by himself.

Field trips

School personnel will notify family of all field trips in advance and will take the following:

1. Cell phone
2. Copy of the student's management plan.
3. Emergency medication

Parent/Guardian Authorization

Student's Name: _____ Date of Birth: _____

I, the parent/guardian/student (if over 18 years of age) of the above named student, understand the health care services stated in the *Health Care Plan for Seizure Management* will be performed by designated school staff under the training and supervision provided by the school nurses (a registered nurse). I will notify the school in writing if there are any changes in my child's treatment plan. I will provide the necessary medication that requires administration during the school day. The Webster School District has my permission to contact the student's physician or their designee about this treatment plan. For the student's safety, I authorize the release of this health plan to the following people:

☐ Principal(s) ☐ School office staff ☐ Health room staff ☐ Lunch room staff
☐ Play ground staff ☐ Hall monitors ☐ Educational assistants ☐ Bus Company
☐ Classroom teachers (school nurse will list by name when form received)

_____

_____

☐ Other _____

Signature: _____ _____

Parent/Guardian **Date**

Physician Authorization

I have reviewed and approved the *Health Care Plan for Seizure Management* for the student named above. I understand that designated school district personnel under the training and supervision provided by the school nurse (a registered nurse will perform specialized health care services.) I agree to be contacted by the Webster School District with regard to his/her plan. This consent remains in effect to the end of the current school year unless it is discontinued or changed in writing.

Signature: _____ **Print:** _____

Date: _____ **Phone:** _____

Area below for district use:

Date received: _____ *Reviewed by:* _____