



Name:	Birth date:
School:	Grade:

THIS STUDENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING SCHOOL HOURS.

Parent/Guardian:	Phone	Phone
Other Contact:	Phone	Phone
Home Address:		
Treating Physician:	Phone	Fax
Treating Physician:	Phone	Fax

SEIZURE INFORMATION:

Seizure Type	Average length	Description

Average frequency: _____
 Seizure triggers or warning signs: _____
 Student's reaction to seizure: _____

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

Follow Basic Seizure First Aid



Does student need to leave the classroom after a seizure? YES NO
 If YES, describe process for returning student to classroom

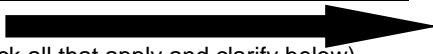
<p>Basic Seizure First Aid:</p> <ul style="list-style-type: none"> ✓ Stay calm & track time ✓ Keep child safe ✓ Do not restrain ✓ Do not put anything in mouth ✓ Stay with child until fully conscious ✓ Record seizure in log <p>For tonic-clonic (grand mal) seizure:</p> <ul style="list-style-type: none"> ✓ 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 _____



<p>A Seizure is generally considered an Emergency when:</p> <ul style="list-style-type: none"> ✓ 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 a first-time seizure ✓ Student has breathing difficulties
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TREATMENT PROTOCOL DURING SCHOOL HOURS:

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

Emergency/Rescue Medication .

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.)

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

School Nurse Consultant Signature: _____ Date: _____