Engage | Learn | Improve

DISTRICT ADMINISTRATION OFFICE
W156N8480 PILGRIM RD
MENOMONEE FALLS, WI 53051
262.255.8440
Website: sdfm.schoolfusion.us

SEIZURE DISORDER CARE PLAN

School Year: _____

Student's Name: _____ School: _____

Date of Birth: _____ Gender: _____ Grade: _____

Parent/Guardian's Name: _____

Mailing Address: _____

Home Phone: _____ Work Number: _____

Cell Phone: _____

Physician: _____Physician's Number: _____ Fax: _____

Allergies to: _____

CURRENT FIRST AID PROCEDURES USED AT SCHOOL:

1. Keep calm. Keep student in reclining position and allow seizure to run its course.
2. Push away nearby objects.
3. DO NOT force a blunt object between teeth.
4. DO NOT restrain student.
5. When student has stopped seizing:
    a. Turn on side
    b. Give rescue breathing, if breathing stops
    c. DO NOT give liquids, if partially conscious
    d. Reorient student to time, person, place and what happened. Reassure student.
6. After seizure, allow student to sleep or rest.
7. Notify parent/guardian. Assess ability to return to class.
8. Call 911 for medical assistance if seizure lasts beyond 5 minutes or if more than one seizure occurs.
9. Written notice of seizure activity to be sent with the child; copy retained at school.
10. Update seizure plan regarding any changes to procedure.

Indicate any changes that should be made to above procedure if needed (i.e. Length of time before notifying parents or summoning ambulance)
Please specify: _____
_____

Type of Seizure Disorder: _____

Medications:

Name	Dosage	Time medication is taken

Possible side effects of medication:

_____

_____

Describe behavior changes prior to onset of seizure (if any):

_____

_____

Describe child's typical seizure:

_____

_____

Date of last seizure: _____

Any limitations or specific instructions per physician (physical education, light, sound level):

_____

_____

This information may be shared with all appropriate staff (including the bus company, if needed)

_____ _____

Student's Signature Date

_____ _____

Parent/Guardian's Signature Date

_____ _____

Health Care Provider's Signature Date

CARE PLAN REVIEWED WITH SCHOOL PERSONNEL

School Representative Signature(s)	Date

4/19/17