SCHOOL DISTRICT OF MENOMONEE FALLS
WISCONSIN

DISTRICT ADMINISTRATION OFFICE
W156N8480 PILGRIM RD
MENOMONEE FALLS, WI 53051
262.255.8440

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