



**SEIZURE MANAGEMENT PLAN**  
**SCHOOL YEAR: \_\_\_\_\_**

Student:	DOB:
School:	Student ID:

<b>PARENTS/GUARDIANS:</b>	
Name:	Name:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
<b><u>IF PARENTS CANNOT BE REACHED:</u></b>	
NAME:	PHONE:

Neurologist:	Pediatrician:
Phone:                      Fax:	Phone:                      Fax:
Medical Facility (Preference):	
Date when seizures started: _____	
What seizures look like: _____	
How long do seizures normally last: _____ How often do they occur? _____	
Date of last seizure: _____	

<b>List all medications student takes (important if student needs medical transport to ER).</b>		
Name:	Dose:	Frequency:
Name:	Dose:	Frequency:
Name:	Dose:	Frequency:

<p><b><u>Management Plan for school (what to do if student has a seizure at school):</u></b></p> <ol style="list-style-type: none"> <li>1. Turn student on side &amp; protect from injury.</li> <li>2. Call for clinic worker or First Responder.</li> <li>3. Time seizure &amp; note characteristics.</li> <li>4. Do not place anything in student's mouth.</li> </ol> <p><b><u>Call 911 if:</u></b>          Seizure lasts longer than 5 minutes          There are multiple seizures without recovery between seizure activity          Difficulty breathing occurs          Significant injury occurs</p> <p><b>Emergency Medication Instructions:</b> _____</p> <p><b>CALL PARENT WHEN:</b> _____</p>
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Does student have a Vagus Nerve Stimulator: <input type="checkbox"/> Yes                      No <input type="checkbox"/>
If yes, describe magnet use: _____

Copy of this plan has been provided to Transportation Supervisor:  Yes                       No

\_\_\_\_\_  
 Parent Signature                                      Date                      Nurse Signature                                      Date

Confidentiality must be upheld when talking to other parents or outside persons. Information about students and family is strictly confidential and all efforts to maintain this are very important.