



SEIZURE MANAGEMENT PLAN

SCHOOL YEAR:

STUDENT:

DATE OF BIRTH:

SCHOOL:

TEACHER:

PARENTS/GUARDIAN	
MOTHER:	FATHER:
HOME PHONE:	HOME PHONE:
WORK:	WORK:
CELL:	CELL:
IF PARENTS CANNOT BE REACHED CONTACT:	
NAME:	PHONE:

PHYSICIAN:	PHONE:	FAX:	
NEUROLOGIST:	PHONE:	FAX:	
MEDICAL FACILITY (PREFERENCE):			
Significant Medical History:			
Date of Last Seizure:			
MEDICATIONS:			
NAME:	DOSE:	TIME:	
NAME:	DOSE:	TIME:	
EMERGENCY MEDICATION:	DOSE:	TIME: (SEE BELOW)	
Seizure triggers or warning signs:		Student's response after a seizure:	
Seizure Type	Usual Length	Frequency	Description

MANAGEMENT PLAN FOR SCHOOL (what to do if student has a seizure at school :	
<ol style="list-style-type: none"> 1. Stay calm 2. Record time & note characteristics 3. Protect from injury 4. Don't restrain or put anything in mouth For Tonic/Clonic generalized seizure: <ol style="list-style-type: none"> 5. Turn child on side; watch breathing 6. Protect head Emergency medication instructions: _____	<div style="border: 1px solid black; padding: 5px;"> <p><u>CALL 911 IF:</u></p> <ul style="list-style-type: none"> • Seizure lasts > 5 minutes • There are multiple seizures without recovery between seizure activity • Difficulty breathing occurs • Significant injury occurs </div>
Notify parent when:	
Does student have a Vagus Nerve Stimulator: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe magnet use:	

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

Parent Signature

County School Nurse Signature

Date