EAGLE COUNTY SCHOOLS

Student Photo

Seizure Health Care Plan and Medication Orders

Effective Date: _____ (Care Plan is good for one calendar year).

Student's Name: _____		Date of Birth: _____
Parent/Guardian: _____	Phone: _____	Cell: _____
Medical Physician: _____	Phone: _____	Neurologist: _____ Phone: _____
Medical history: _____		
Allergy to: _____		

SEIZURE INFORMATION:

Seizure Type: Tonic/clonic, Absence, Myotonic	*Length*	*Frequency*	*Description*
Seizure triggers or warning signs, Aura:			

Basic First Aid:

Basic Seizure First Aid:
- ☐ Stay calm & track time on seizure record
- ☐ Keep child safe
- ☐ Do not restrain
- ☐ Do not put anything in mouth
- ☐ Stay with child until fully conscious
- ☐ Record seizure in log

For tonic-clonic (grand mal) seizure:
- ☐ Protect head
- ☐ Keep airway open/watch breathing
- ☐ Turn child on side

Emergency Response:

A Seizure is generally considered an Emergency when:
- ☐ 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 breathing difficulties
- ☐ Student has a seizure in water

☐ Contact school nurse ☐ Call 911 for transport to _____
☐ Notify parent or emergency contact ☐ Notify doctor
☐ Administer emergency medications as indicated below
☐ Other _____

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

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

☐ Yes See attached list of Meds used at home

☐ Yes Student does have a Vagus Nerve Stimulator (VNS)?
Describe magnet use: _____

☐ Yes Emergency Medications must accompany student on field trips, sporting events etc.

If there is a change in health (such as a change in medication or a hospitalization), please contact the health office so that this care plan can be revised if needed. Parent's signature indicates permission to contact child's health care provider(s) as needed. I understand that the School Nurse will delegate this care plan to unlicensed school personnel and give permission for school staff to carry out this care plan. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure this child's safety and well-being while at school or during school related activities.

Physician: _____	Signature: _____	Date: _____
Parent: _____	Signature: _____	Date: _____
Nurse: _____	Signature: _____	Date: _____

Dates Copy sent to Health care Provider: _____ Parent: _____