

**Pulaski County Schools
Seizure Disorder Health Care and Emergency Plan**

Student's Name _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____

Other Emergency Contact: _____ Phone: _____

Treating Physician: _____ Phone: _____

Significant Medial History: _____

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Basic seizure First Aid

- Stay calm & track seizure time and activity
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Document seizure activity
- Protect head from injury
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered and emergency when:

- Convulsive seizure lasts longer than 5 minutes
- Student has repeated seizures without gaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has seizure in water

Seizure Emergency Protocol: (check all that apply):

- Contact school nurse at _____
- Call 911
- Notify parent or emergency contact
- Administer emergency medications as ordered
- Other: _____

Treatment Protocol during School Hours (include daily and emergency medications)

Emergency Medication	Medication	Dosage & Time of Day Given	Special Instructions

Does student have a Vagus Nerve Stimulator? Yes No If YES, describe magnet use:

Describe any special considerations and precautions regarding school activities, sports, trips, etc.: _____

Physician Signature _____ Date: _____

Parent/Guardian Signature _____ Date: _____

Student Name: _____ DOB: _____

The Parent/Guardian should complete the following:

Physician Name: _____ Date last seen for this condition: _____

How many times has your child been seen in the emergency room for this condition in the last year? _____

Age of onset of Seizures: _____ Date of last Seizure: _____ Time/length of Seizure: _____

Please list known triggers for seizure activity: _____

Please list any warning signs and/or a behavioral change that may indicate a seizure is about to occur: _____

Please list any special precautions for field trips/transportation to and from school: _____

Parent/Guardian Consent: I have reviewed and approve this health and emergency care plan for my child. I authorize unlicensed trained personnel of Pulaski County Schools to administer medication to my child as prescribed by physician and to provide emergency treatment as written in the above plan in the absence of the school nurse. I understand that I am responsible for supplying any medication, supplies or equipment needed by my child to manage his/her seizure disorder at school. I authorize the school to contact my child's physician regarding my child's health condition. This health care plan can be updated at any time my child's circumstances require modifications in treatment, but will be reviewed annually. I agree to notify the school if a change occurs in my child's health plan. I also consent to the release of the information contained in this care plan to Pulaski County School personnel who care for my child and who may need to know this information to maintain my child's health and safety.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

The following staff members have been trained to administer medication and assist with this student's care at school in the absence of the school nurse.

1.
2.
3.
4.