

SEIZURE EMERGENCY CARE PLAN

Pleasantdale District 107

Student Name:		Teacher/Team:
Grade:	DOB:	

Emergency Contacts:

	Name	Relationship	Home Phone	Work Phone	Cell Phone
1					
2					
3					

Physician:	Phone:
Hospital:	Phone:

Health Concern:

Allergies:

Seizure History:
Medication(s):
Frequency:
Describe typical seizure:
Known triggers/pre-seizure aura:

1. PREVENT INJURY

- Note onset time of seizure
- Clear area around child of hard objects
- Turn child on side to prevent aspiration
- Cushion under head with something soft
- Loosen tight clothing
- Remove glasses
- Remain calm and softly reassure child

DO NOT RESTRAIN OR ATTEMPT TO PUT ANYTHING INTO THE MOUTH

2. MONITOR- GET ASSISTANCE NOTIFY HEALTH OFFICE FOR ASSISTANCE ASAP

- Note length of and type of seizure activity (Note exactly what the person did during the seizure, movement by movement. Note time when seizure started and stopped.)
- Notify primary emergency contact (parent/guardian)

IF SEIZURE LASTS MORE THAN 5 MINUTES, CHILD IS IN RESPIRATORY DISTRESS, ASPIRATES VOMIT, OR SERIOUS INJURY OCCURS – CALL 911

3. NOTIFY EMERGENCY CONTACTS

4. COMPLETE SEIZURE FLOW SHEET

In case of serious illness and I cannot be reached I authorize school personnel to contact:

Physician/Clinic: _____

or transport by ambulance to: _____
Hospital

I give permission for my child's health plan to be shared with pertinent school staff during the current school year.

Parent Signature: _____ **Date:** _____

MD Signature: _____ **Date:** _____

Note: Per school district policy, signed physician prescription, parent authorization, and medication in the original container are required for any medication administration at school.

for school use only:

Medication: _____ Date received: _____

Date physician orders received: _____

Medication: _____ Date received: _____

Date physician orders received: _____