Seizure Medical Management Plan

Student Name_____ID #_____DOB_____Grade/School year_____

Provider Name/Clinic_____Phone_____Date of Seizure Diagnosis_____

Seizure Information

Seizure Type	Length	Frequency	Description

Medication taken at home

Emerg. Med. √	Medication	Dosage & Time of Day Given	Common Side Effects & special Instructions

Signs of Seizures (Please check behaviors that apply to student)

SEIZURE SYMPTOMS	**DANGER SIGNS—CALL 911**	BEHAVIORS AFTER SEIZURE
□ lip smacking □ behavioral outbursts □ staring □ twitching □ sudden cry or squeal □ falling down □ rigidity/stiffness □ thrashing/jerking □ loss of bowel/bladder □ shallow breathing □ blue color to lips □ froth from mouth □ gurgling/grunting □ loss of consciousness □ other_____	-- Seizure lasts more than 5 minutes -- Student has repeated seizures without regaining consciousness -- Student has breathing difficulties -- Student has a seizure in water -- If seizure is the result of an injury or child is injured during seizure	□ tiredness □ weakness □ sleeping, difficult to arouse □ somewhat confused □ regular breathing □ other_____ Behaviors usually last _____ _____

Medication/Treatment Protocol During School Hours

Emerg. Med. √	Medication	Dosage & Time of Day Given	Common Side Effects & special Instructions

Other Protocol_____

_____

Does student have a **Vagus Nerve Stimulator?** □ Yes □ No If Yes, describe magnet use _____

IF YOU SEE THIS	DO THIS
SEIZURE ACTIVITY	Stay calm. Move surrounding objects and protect head to avoid injury. DO NOT hold student down or put anything in the mouth. Loosen clothing if needed. Roll student on his/her side. Document seizure activity on seizure observation record. If applicable administer medications or use VNS as ordered. Notify parent/guardian.
STOPS BREATHING	Begin CPR/Rescue Breathing. Call 911.
LOSS OF BOWEL OR BLADDER CONTROL	Cover with blanket or jacket. If necessary, discreetly assist with changing of clothes after seizure.
DANGER SIGNS-(SEE ABOVE)	Call 911. Call parent/guardian.
FALLS DOWN, LOSS OF CONSCIOUSNESS	Help student to the floor for safety; observe for injury/seizure. Call School Nurse
VOMITING	Turn on side.

I request designated staff to administer the medication as prescribed by the licensed provider above. I certify that I have legal authority to consent to the administration of medication at school. I authorize the school nurse to communicate with the licensed prescriber regarding the administration of this medication.

Parent/Guardian Signature_____ Phone_____ Date_____

Provider Signature_____ Phone_____ Date_____

School Nurse Signature_____ Date_____