East Allen County Schools
HEALTH SERVICES
Seizure Medical Management Plan

School Year 20___ - 20___

Student's Name: ___________________________________ Birth Date: ____________ Grade: ____

Parent/Legal Guardian: ____ Phone: ___________________

Emergency Contact: ____ Phone: ___________________

Treating Physician ____ Office Phone ____________________________

Significant Medical History: ____

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SEIZURE INFORMATION

Seizure Type	*Length*	*Frequency*	*Description*

Seizure triggers or warning signs: ____

Student's response to seizure: ____

Basic First Aid/Care & Comfort: (*Describe basic first aid procedures*)

____

____

Does student need to leave the classroom after seizure? ☐ NO ☐ YES If YES, describe process for returning student to classroom: ____

EMERGENCY RESPONSE: *A "seizure emergency" for this child is defined as:*

____

____

Seizure Emergency Protocol: (*Check all that apply*)

☐ Contact school nurse (RN) at extension __________

☐ Call 911 for transport to ____________________________________

☐ Notify parent or emergency contact

☐ Administer emergency medications as indicated below

☐ Notify doctor

☐ Other____

Basic Seizure First Aid:
- Stay calm and track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Document seizure

For tonic-clonic seizure:
- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered an Emergency when:
- 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

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

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

Does student have a **Vagus Nerve Stimulator (VNS)**? ☐ NO ☐ YES

If YES, describe magnet use ____

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SPECIAL CONSIDERATIONS & SAFETY PRECAUTIONS: (regarding school activities, sports, field trips, etc.)

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Physician Signature: ____ Date: ________________

Physician's Name (PRINTED) ____

I want this plan implemented for my child. I hereby give my permission for exchange of confidential information contained in the record of my child between the school nurse and physician/physician's designee and my signature is an informed consent to share this medical information with school staff as need to know for academic success and emergency plan as determined by the school nurse. I understand there is no liability on part of the school district, its agents or its personnel for civil damages as a result of assisting with this procedure (Seizure Medical Management Plan) when the person acts as an ordinarily reasonable and prudent person would have acted under the same or similar circumstances.

In the event of an emergency situation, and the school is unsuccessful in contacting the parent/legal guardian and emergency contact, this student will be EMS transported to the nearest hospital, unless hospital preference is noted above.

I authorize East Allen County Schools, to copy this form and give to emergency medical personnel in the event of a medical emergency requiring EMS transport.

Parent/Legal Guardian Signature: __________________________________ Date: _________________