SEIZURE EMERGENCY CARE PLAN 2016-2017 SCHOOL YEAR
GREENFIELD-CENTRAL COMMUNITY SCHOOL CORPORATION

Student's Name: _____ Date of Birth: _____

Student's Address: _____

EMERGENCY CONTACTS

	Name	Relationship	Telephone	Email
1.				
2.				
3.				

EMERGENCY PLAN OF ACTION

1. If the student exhibits any signs of a seizure, call the clinic immediately. Note the time the seizure began.
2. Protect the student from injury during the seizure. Remove any hard or sharp objects from the immediate area. Do not attempt to restrain the student's movements. Do not place any object into the student's mouth. If available, place a blanket, jacket, pillow, etc., under student's head.
3. If student begins to vomit, turn him/her on their side.
4. Do not leave the student alone, but evacuate students, visitors and unnecessary staff from the area.
5. Following the seizure, document what happened before, during and after the seizure, time seizure began and length of seizure, and what seizure activity was present.
6. Notify parents of the seizure activity.
7. Call 911 immediately if any of the following are present:
    a. Absence of breathing and/or pulse – begin CPR for respiratory or cardiac arrest
    b. Seizure lasts five minutes or greater
    c. Two or more consecutive seizures
    d. Any difficulty breathing
    e. Student continues to have pale or bluish skin/lips or noisy breathing after the seizure has stopped

SEIZURE INFORMATION – Completed by Physician

Type of seizures:

□ Complex Partial □ Febrile Seizure □ Absence □ Generalized tonic-clonic □ Other _____

What does the seizure look like and how long does it usually last? _____

_____

Seizure triggers or warning signs: _____

Are there any activities this student may not participate in while at school?

□ No, student may fully participate in all activities. □ Yes, student should not participate in (please list excluded activities): _____

(-OVER-)

Does the student take medications **at home** on a daily basis to control seizures? □ No □ Yes (please list):

Medication and Dosage

1. _____
2. _____
3. _____

Does the student require rescue medication for seizure activity? □ No □ Yes (please list):

Medication, Dosage and Route (Form 5330F1 must also be completed for this medication to be given.)

1. _____
2. _____

Does the student have a Vagus Nerve Stimulator (VNS)? □ No □ Yes (please describe) _____

Comments or Special Instructions from Physician: _____

_____

Physician's Signature: _____ Date: _____

SEIZURE INFORMATION – Completed by Parent/Guardian

In addition to the above instructions from the physician, I wish to communicate the following information to school personnel regarding my student:

_____

_____

_____

As the parent/guardian of a student with seizures, I understand it is **my** responsibility to inform bus drivers, coaches, extra-curricular sponsors, tutors, etc., of my student's condition. I agree to and wish to implement this emergency care plan for my student. My student understands the importance of reporting symptoms immediately to the school health assistant. I hereby give permission for the exchange of medical information between the corporation nurse, health assistant, school principal, and the physician listed above. I also give permission for clinic personnel to share this medical information with school staff as needed to help protect my student's safety and well-being.

Parent/Guardian's Signature: _____ Date: _____

Printed Name: _____

TO BE COMPLETED BY SCHOOL PERSONNEL

Date ECP received by clinic personnel: _____

□ ECP Reviewed by Health Assistant _____

□ ECP Reviewed by Corporation Nurse _____