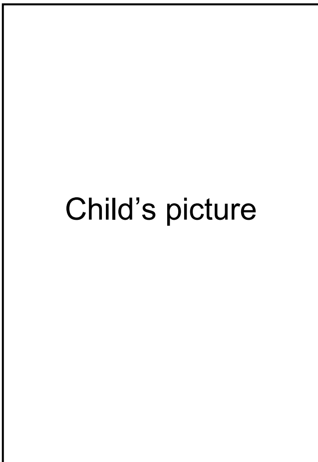
UTICA COMMUNITY SCHOOLS
SEIZURE HEALTH CARE PLAN



EFFECTIVE DATE:________________________________

To be completed annually by parents/health care team and reviewed with necessary school staff-copies should be kept in the student's classroom and school record.

Student's Name: ____

DOB _______________ Grade: ______Teacher: _________________________________

Reviewed by: ____(health care provider)
Signature Date

Acknowledged by____(parent/guardian)
Signature Date

Acknowledged by:____(school rep.)
Signature Date

♦ Contact Information

Parent #1 Name ______________________________ Parent #2 Name ____

Parent/Guardian #1: Telephone-Home___________________ Work ____________________Cell____________________________

Parent/Guardian #2: Telephone-Home___________________ Work ____________________Cell____________________________

Student's Doctor/Health Care Provider________________________________Phone_______________________________________

Other Emergency Contact_____________________Relationship_____________________Phone___________________________

Notify parent/guardian in the following situations:____

Trained school personnel: ____Dates of training ______________________________

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♦ Seizure Information

How often do the seizure occur?____

Has hospitalization been needed in past year for seizures? ☐No ☐Yes (When?)

Seizures are currently being treated by Dr.:____

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

____

____

List conditions that generally cause the seizure (e.g. noise, blinking lights)____

____

Does your student need any special activity adaptations/protective equipment (e.g., helmet) at school? ☐No ☐Yes

(Describe)____

How long after the seizure before the student can return to his/her regular activities?____

____

♦ Medications

ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? ☐No ☐Yes (list medications below)

Medication	Dose/Route	When to use

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♦ School Procedure For A Student Having A Seizure

1. Stay with student through seizure, speaking gently.
2. Provide for student safety by removing nearby hazardous objects, loosening clothing at neck and waist, **protecting head from injury**, as pertinent.
3. Remove other students from the immediate area to give privacy as possible.
4. **Time the seizure**.
5. Observe student for inadequate breathing/continuous seizing; when seen call **9-1-1**
6. **Advise parent of the seizure**.
7. Reorient the student and guide student to safe location.
8. Provide rest for student as needed after the seizure.

If you want any additional help given, or have other concerns, describe here:

____

____

____

Call 911 if:

1. **Seizure lasts longer than __________ minutes.**
2. **A cluster of _____ seizures in _____ minutes with return of baseline awareness between seizures.**
3. **A cluster of _____ seizures in _____ minutes without return of baseline awareness between seizures.**

♦ Transportation

Special Needs Medical Information Form Completed?	Yes	No
Additional Medication/supplies needed for bus?	Yes	No