Health Related Services

Seizure Questionnaire and Plan

Date:________________________

Student:______________________________ **DOB:**______________ **Valid for school year:**_____________

Please complete this form for your student's seizure needs so staff can plan effectively for their care while at school.
Please note: If your student is participating in activities before and after the school day including: after school care, extracurricular activities/trips, athletics, or camps, it is imperative that YOU inform the supervising adults of this student's medical needs. This is necessary because the school may not be aware of all activities the student is participating in beyond the normal school day/year.

Seizures are currently being treated by Dr. _________________________ Phone #: ____________________
Please sign to give consent for the exchange of medical information with the above physician and the school.

Signature: ____Relationship:__________________________
When was student diagnosed with seizures or epilepsy? ___________________Last seizure:_____________

Seizure type(s)	*Length*	*Frequency*	*Description*

Has hospitalization been needed in the past for continuous seizures? □ No □ Yes (when ___________)
What might trigger a seizure for this student?____
Are there any warnings and/or behavior changes before a seizure occurs? □ No □ Yes (explain)___________
____
How does your student react after a seizure?____

Does your student have a Vagus Nerve Stimulator? □ No □ Yes (please provide model type and directions for use) ____
List the student's current Seizure Medication:

MEDICATION	**AMOUNT TAKEN**	**HOW OFTEN AND FOR WHAT SIGNS?**
1. ______________________________	__________	____________________________________
2. ______________________________	__________	____________________________________
3. ______________________________	__________	____________________________________

□ This student is aware of the signs and symptoms of an oncoming seizure and knows to tell an adult. They usually state they feel:____
□ This student carries their emergency medication with them.
□ This student will leave their emergency medication in the school medical clinic.

If medications must be given during school hours, an **Authorization for Medication** form HRS-29 must be completed every school year. It must be filled out and signed by you and your physician. Medications used in school must be in the original container. When you have a prescription filled, ask the pharmacist for two containers; one for school and one for home use. If your student participates in field trips and needs medication during that time, a separate container with the current prescription is necessary for that day as well. Your Pharmacy will provide you with a "travel" Rx bottle.

Seizure Plan

Student:______________________________ DOB:___________ Valid for school year:______________

Basic Seizure First Aid:

- **Stay calm and <u>note time seizure started</u>.**
- **Keep student safe from self-injury.**
  - **Protect from walking into object if partial seizure.**
  - **Protect head if tonic-clonic/grand mal seizure.**
  - **Do not restrain.**
  - **Do not put anything in their mouth.**
  - **Stay with student until fully conscious.**
- **Reassure and reorient when coming around. Notify guardians.**
- **Other:____**

When to call 911:

- **Student has breathing difficulties.**
- **If a seizure last longer than 5 minutes. Give Diastat if available while waiting on EMS. Send used medication syringe with EMS.**
- **Student has repeated seizures without regaining consciousness.**
- **Student has a first time seizure.**
- **Student is injured or diabetic.**
- **Other:____**