Desoto County Schools Seizure Care Plan

Student Name: _____ Date of Birth: _____

School: _____ Grade: ____ Homeroom Teacher: _____

Seizure Triggers or Warning Signs: _____

Student's usual seizure activity includes: _____

Emergency Medication: _____ When to give: _____

Where will emergency medication be stored? _____

Does student have a Vagus Nerve Stimulator? ___Yes ___ No If yes, instructions for use: _____

Basic First Aid for Seizures

Assist student to the floor, if needed

Clear area to protect student from injury (Place something soft under their head)

Start a written record of the time the seizure started, as well as, record of behavior, including length of seizure

Do Not Restrain

Do Not put anything in the mouth

Keep Airway open

Turn student on their side

Give emergency medication as ordered

Start CPR, if necessary

Call 911 if:

Seizure activity is different from "usual" seizure activity

Student's breathing is affected

Seizure last longer than **5 minutes; unless otherwise noted by the physician**

After the seizure

Permit the student to rest

Continue to document the episode and monitor for a 2nd episode

Monitor for confusion or lack of consciousness

Current Medications

1. _____ Dose _____ Times given _____
2. _____ Dose _____ Times given _____
3. _____ Dose _____ Times given _____

If I cannot be reached by phone and my child does not respond to treatment, I give my permission for school staff to call the physician listed below and to follow his/her instructions. If the physician orders hospitalization or my child is exhibiting symptoms of a medical emergency, my child will be transported to the nearest hospital. I also understand that school staff can and will be informed of my child's health concerns in order to provide safe, appropriate care.

Parent/Guardian Signature**:** _____ Date _____

Physician Signature: _____ **Date** _____

Physician Office Stamp: