



# Emergency Care Plan



## SEIZURE DISORDER

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ School Contact: \_\_\_\_\_ DOB: \_\_\_\_\_

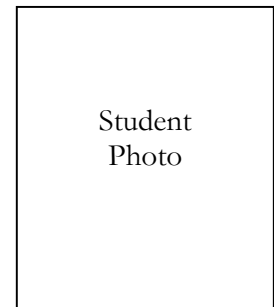
Mother: \_\_\_\_\_ MHome #: \_\_\_\_\_ MWork #: \_\_\_\_\_ MCell #: \_\_\_\_\_

Father: \_\_\_\_\_ FHome #: \_\_\_\_\_ FWork #: \_\_\_\_\_ FCell #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### SYMPTOMS OF A SEIZURE EPISODE MAY INCLUDE ANY/ALL OF THESE:

- Tonic-Clonic Seizure:
  - o Entire body stiffens, jerking movements
  - o May cry out, turn bluish, be tired afterwards
- Absence Seizure:
  - o Staring spell, may blink eyes



### STAFF MEMBERS INSTRUCTED:

- Administration
- Classroom Teacher(s)
- Support Staff
- Special Area Teacher(s)
- Transportation Staff

### TREATMENT:

Clear the area around the student to avoid injury.  
**DO NOT PUT ANYTHING IN THE STUDENT'S MOUTH**  
 Place student on side if possible, speak to student in reassuring tone  
 Stay with student until help arrives

- Emergency Medical Services (911) should be called, student transported to hospital  
 Preferred Hospital if transported: \_\_\_\_\_
- Emergency medication to be given by Nurse at onset of seizure**
- Student should be allowed to rest following seizure, call parent

**Transportation Plan:**  Medication available on bus  Medication NOT available on bus  Does not ride bus

Special instructions: \_\_\_\_\_

Healthcare Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Written by: \_\_\_\_\_ Date: \_\_\_\_\_

- Copy provided to Parent
- Copy sent to Healthcare Provider

**Parent/Guardian Signature** to share this plan with Provider and School Staff: \_\_\_\_\_