Brandon Valley School District
Health Services

Seizure Disorder Health Care Plan

Students Name: _____ Birthdate: ___/___/___ Bus: □ Yes □ No

School: _____ Teacher: _____ Grade: _____

Parent/Guardian: _____ Phone: _____

_____ Phone: _____

Emergency Contact: 1) _____ Phone: _____

2) _____ Phone: _____

Neurologist: _____ Phone/Fax: _____/_____

Preferred Hospital: _____

Seizure Information to be completed by parent:

When was your child diagnosed with a seizure disorder? _____ When was your child's last seizure? _____

Seizure Type (s):

Seizure Type	Length	Frequency	Description

1. What might trigger a seizure in your child? _____
2. Are there any warnings and/or behavior changes before the seizure occurs? Yes No
   If yes, please explain:
   _____
3. Has there been any recent changes in your child's seizure patterns? Yes No
   If yes, please explain:
   _____
4. How does your child react after a seizure is over? _____
5. Has your child ever required hospitalization due to a seizure? Yes No
   If yes, please explain:
   _____
6. Does your child need protective equipment? Yes No
   If yes, please explain:
   _____
7. Does your child take any medication at home for their seizure disorder? Yes No
   If yes, please list:

Medication	Dose	Time

TREATMENT DURING SCHOOL HOURS: (Include daily and emergency medications)
**** To Be Completed by a Physician****

Medication at school	Dosage and Time given	Special Instructions/Side Effects

****All medication given at school will need a signed Medication Authorization Form****

Basic First Aid	Seizure Emergency	Seizure Emergency Protocol
• Contact School Nurse • Stay calm • Track time • Keep student safe • Do not restrain • Do not put anything in mouth • Stay with child until fully conscious • Protect student's head • Keep airway open and watch breathing • Turn student on their side	• **Convulsive seizure lasting longer than 5 minutes** • **Student has repeated seizures without regaining consciousness** • **Student has a "first time" seizure** • **Student is injured or has diabetes** • **Student has breathing difficulties**	• **Contact School Nurse** • **Call 911** • **Notify parent/guardian or emergency contact** • **Administer emergency medication** • **Other _____**

Physician Signature _____ Date _____

*****A **"Consent and Request for Medication during School Day" Form** must be completed and kept on file in the school health office. Parents are responsible for providing all new health forms, including this Health Care Plan, by the first day of each school year. Any updates throughout the school year should be submitted to the School Nurse.

** This information will become part of your child's confidential permanent record. If for any reason you do not wish to respond to part of this form you are under no obligation to do so. Please understand that we are not responsible for injury or illness that may be a result of these omissions.*

By signing below I understand that I am giving my permission to share this information with school staff/trained personnel as needed with strict confidentiality maintained by all. I also give my permission for the school nurse to contact the Primary Care Physician or Allergist if further information is needed.

Parent Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____