SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES
SEIZURE FIRST AID CARE PLAN

Student: _____ DOB: _____ Grade: _____

School: _____ Teacher: _____ School Year: _____

Allergies: _____

Significant Medical History: _____

_____

CONTACT INFORMATION

Parent/Guardian: _____ Hm: _____ Cell _____ Wk _____

Parent/Guardian: _____ Hm: _____ Cell _____ Wk _____

Neurologist _____ Phone _____ Fax: _____

SEIZURE HISTORY:

When was child diagnosed with seizures or epilepsy? _____ Date of last seizure: _____

Type of seizure: _____ How often do seizures occur? _____

Description the seizures: _____ Typical seizure length (time)? _____

What will trigger a seizure? _____

Warning signs before seizure? _____

Student's behavior **during** a seizure? _____

Student's behavior **after** a seizure? _____

Does child wear a helmet at school? _____ Does child have a Vagus Nerve Stimulator? _____

List medications child receives: _____

SEIZURE EMERGENCY A Seizure is generally considered an Emergency when:

- A convulsive seizure lasts longer than 5 minutes OR repeated seizures without regaining consciousness.
- Child has a first time seizure, is injured or has diabetes, has breathing difficulties, or child has a seizure in water.

EMERGENCY RESPONSE FOLLOW SEIZURE FIRST AID:**

- ✓ Stay calm & track time. Stay with the student.
- ✓ Keep child safe. Protect from obvious hazards or from falling.
- ✓ Lay child down on the floor on their side. Do NOT shout, restrain, or restrict movements.
- ✓ Turn head to the side to prevent aspiration or choking. Do not put anything in mouth
- ✓ Monitor breathing/airway. Do not use artificial respiration unless breathing is absent after jerks subside.
- ✓ Observe for any injury, the color of lips, face and skin, breathing. Note time, length of seizure (by clock).
- ✓ Call parent and/or Emergency Contact.
- ✓ Call 911 if seizure continues after 5 minutes.
- ✓ When seizure is finished, the student may be sleepy and have no memory of actions.
- ✓ Record seizure on Observation Record.
- ✓ Student must be continually monitored until released to parent/guardian. Student needs 4 hours of observation.

** If any medication is required at school, a separate Protocol is required. Contact Health Services.

SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES

HEALTH HISTORY INFORMATION

Student: _____ **DOB:** _____ **Grade:** _____ **School:** _____

The above student has the following condition(s):

1. _____
2. _____
3. _____

Please provide us with the following information so that we may have a better understanding of your child's needs while at school.

1. Is your child under the care of a physician for the above condition(s): Yes/No
2. Has your child had a problem with this condition in the last year? Yes/No

   Physician's name: _____ ***Phone #:*** _____
3. Should your child's activities at school be restricted in any Way? (Please explain) Yes/No

   _____

   _____
4. Does your child taken medication for this condition? Yes/No

   Name of medication*:* _____ Dosage*:* _____

   Name of medication*:* _____ Dosage*:* _____

   Name of medication*:* _____ Dosage*:* _____
5. What action do you want the school to take when your child is sent to the Health Office for a problem?

   _____

   _____
6. Please list any other information that might be helpful in caring for your child.

   _____

   _____

   _____

   _____

PARENT'S AUTHORIZATION FOR EXCHANGE OF INFORMATION: I authorize the school nurse to communicate with the physician when necessary. I hereby give my permission for exchange of confidential information contained in the record of my child.

Parent Signature: _____ **Date:** _____

Reviewed by Health Services _____ **Date:** _____

SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT HEALTH SERVICES
SEIZURE FIRST AID CARE PLAN

Student: _____ **DOB:** _____ **Grade:** _____ **School:** _____

Parent Consent for Management of Seizures at School

I (We), the parent/guardian of the student named below, request that the above regimen for Management of Seizures in school be administered to our child in accordance with state laws and regulations. I will:

1. Provide the necessary supplies and equipment, including a 3 day emergency supply of medication.
2. Notify the school if there is a change in student health status or change of physician.
3. Notify the school immediately and provide new consent for any changes in doctor's orders.
4. Notify the school if student has received emergency medication or anti-seizure medication in the last 24 hours.

California Education Code Section 49423 allows the district nurse or other designated non-medical personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school and to maintain, or improve his/her potential for education and learning.

I understand that designated non-medical school personnel may assist in carrying out written orders under supervision of a qualified District Nurse. I will notify the school immediately and submit a new form if there are changes in medication dosage, time of administration and/or the prescribing authorized health care provider. I give my permission for the District nurse to exchange verbal and written medication-related information with the authorized health care provider.

The District Nurse may counsel appropriate school personnel regarding the medication and its possible effects.

Parent Signature: _____ **Date:** _____

District Nurse Signature: _____ **Date:** _____