THE SCHOOL BOARD OF HERNANDO COUNTY, FLORIDA

Seizure Disorder Care Plan

Please Print - (TO BE COMPLETED BY PARENT)

Student's Name _____Student's I.D. Number _____

School _____Grade _____ Date of Birth _____

Parent(s)/Guardian(s) _____

Home Phone _____ Work _____ Cell _____ Beeper _____

Emergency Contact _____ Phone _____ Other _____

Physician's Name _____ Phone _____

Physician Treating Seizures _____ Phone _____

Allergies: _____

1. What type of seizures does your child have? _____

2. Does your child have other health problems/concerns? _____

_____

3. At what age did seizure activity begin? _____ When was the last seizure? _____

4. Is there any known specific cause for these seizures? If so please explain briefly. _____

_____

_____

5. Describe the seizure: _____

_____

_____

6. How long do the seizures normally last? _____

7. Has a seizure ever lasted longer than 5 minutes? ____ Yes ____ No. If yes, what intervention was needed. _____

_____

8. Does your child lose bowel or bladder control during a seizure? ____ Yes ____ No

DISTRIBUTION:
White: Clinic
Yellow: Parent

9. Has your child ever turned blue or stopped breathing during a seizure? ____ Yes ____ No
   If yes, what intervention was needed? _____

10. Has your child ever required hospitalization due to a seizure? ____ Yes ____ No
    If yes, please explain _____

11. Is there anything that seems to trigger a seizure? (i.e. flashing lights; video games, computers),
    ____ Yes ____ No If yes, please explain _____

12. Are there any warnings or behavior changes before a seizure? ____ Yes ____ No
    If yes, please explain _____

13. Are there any limitations to your child's activities? ____ Yes ____ No
    If yes, please be specific and attach a physician's order _____

    _____

14. Does your child require any protective equipment, e.g. helmet? ____ Yes ____ No
    If yes, please explain _____

    _____

15. Other considerations: _____

16. May we contact your child's doctor with questions about your child's seizures or treatment?
    NOTE: you must sign A Release of Medical Information prior to our contacting the physician.
    Clinic personnel has this form.

    ____ Yes ____ No

17. List ALL medications your child takes including those at school (an additional medication form and
    Physician prescription must be submitted for all medications administered in school)

    _____

    _____

    _____

Physician's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

NOTE: FOLLOWING AN OBSERVED SEIZURE, PLEASE COMPLETE THE SEIZURE OBSERVATION FORM AND GIVE TO PARENT.

THE SCHOOL BOARD OF HERNANDO COUNTY, FLORIDA
HEALTH CARE ACTION PLAN

Student Name _____ Date _____

(Copy to be readily available in classroom and clinic)

EMERGENCY PLAN

IN AN EMERGENCY

1. Stay with child
2. Call/ask someone to call clinic assistant who will assess child and summon EMS for this child/or instructor may call EMS.

If You See This	Do This
Based on this child's current condition a **medical emergency** for this child is:	

IMPORTANT EMERGENCY NUMBERS:

Mother's Name _____ Work (___) _____ Home (___) _____

Cell (___) _____

Father's Name _____ Work (___) _____ Home (___) _____

Cell (___) _____

Emergency Contact's Name _____ Phone Number:_____

Preferred Hospital: _____

Primary Physician: _____

Specialist(s): _____

DISTRIBUTION:
White: Clinic
Yellow: Parent

THE SCHOOL BOARD OF HERNANDO COUNTY, FLORIDA

Teacher Information Sheet

Student's Name _____School Year _____

Student Number _____ Date of Birth _____ Grade _____ Date _____

This student has epilepsy or seizure disorder. This information should assist you if a seizure occurs during class.

Seizure type _____

Description of seizure _____

_____

_____

Average frequency of seizures _____

Usual time of day of seizures _____

Things that may trigger a seizure _____

Average length of seizure in minutes _____

Average length of time until student returns to regular activities _____

First aid you should provide: _____

_____

_____

After seizure, do the following: _____

_____

_____

Student takes the following medication(s):

Medication _____ Medication _____

Time given _____ Time given _____

Side effects _____ Side effects _____

_____

Report immediately if you notice _____

_____

Comments _____

_____

_____

Completed by: _____

Phone number(s) _____

THE SCHOOL BOARD OF HERNANDO COUNTY, FLORIDA

Seizure Observation Form

Student's Name _____ Student Number _____ Date _____

Location of seizure _____

1. What was student doing **BEFORE** the seizure?

   A. Was the student: alert ____ sleeping ____ other _____

   B. How long did the seizure last? _____ (Do not include time sleeping after the seizure).

   C. Did the student experience a warning? ____ Yes ____ No. If Yes, describe it

   _____

   _____

2. Check the events you saw **DURING** the seizure (number in the order they happened if possible).

☐ Eyes turned up and fixed left	☐ Eyes turned up and fixed right	☐ Picking movements
☐ Head turned and fixed left	☐ Head turned and fixed right	☐ Respective lip smacking/chewing
☐ Impaired speech	☐ Stared	☐ Fell
☐ Lost consciousness	☐ Unresponsive	☐ Cried out
☐ Stiffening on left side	☐ Stiffening on right side	☐ Stiffening on both sides
☐ Jerking on left side	☐ Jerking on right side	☐ Jerking on both sides

☐ Confusion or disorientation, how long? _____

☐ Other _____

3. Check the things you saw **DURING** the seizure:

☐ Drooling	☐ Lost bladder control	☐ Lost bowel control
☐ Became pale or turned blue	☐ Bit tongue	☐ Became flushed
☐ Blinked eyes	☐ Walked around	

☐ Other _____

4. Check the things you saw **AFTER** the seizure:

☐ Confusion or disorientation. How long? _____

☐ Complained of headache	☐ Complained of body aches
☐ Nausea	☐ Vomited
☐ Complained of weakness	☐ Slept. How long? _____

☐ Injuries. Describe _____

☐ Other _____

5. Was the student sent to clinic? _____ Yes _____ No. If yes, arrival time: _____

NAME OF PERSON WHO SAW THE SEIZURE: _____

Name of person filling out this form (if other than above): _____

COPY OF THIS FORM TO BE SENT HOME WITH STUDENT AFTER EVERY SEIZURE AND COPY TO STUDENT HEALTH FILE IN CLINIC

DISTRIBUTION:
White: Clinic
Yellow: Parent