



**Clarksville-Montgomery County School System**  
**HEALTH SERVICES**  
**SEIZURE INDIVIDUAL HEALTH CARE PLAN**  
*School Year 20\_\_ - 20\_\_*

**\*\*\*Parent/guardian completes page one\*\*\* PLEASE PRINT\*\*\* Physician completes page two\*\*\***

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent(s)/Guardian(s): \_\_\_\_\_

Contact information - phone or pager numbers at home/work for parent(s)/guardian(s)

\_\_\_\_\_

Other contacts (please list two) in event that parent/guardian cannot be reached:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Health Care Provider Information**

Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Hospital (In event that your child needs hospital care): \_\_\_\_\_

**Triggers that may bring on a seizure:** \_\_\_\_\_

\_\_\_\_\_

**Signs and Symptoms:** (Please check the symptom(s) that occur in your child.)

- |  |  |
|--|--|
| <input type="checkbox"/> Aura symptoms before seizure                  | <input type="checkbox"/> Loss of consciousness           |
| <input type="checkbox"/> Generalized convulsions involving entire body | <input type="checkbox"/> Staring/blank gaze/day dreaming |
| <input type="checkbox"/> Labored (noisy) breathing                     | <input type="checkbox"/> Pallor or skin discoloration    |
| <input type="checkbox"/> Involuntary loss of urine or feces            | <input type="checkbox"/> Dilation of pupils              |

Is your child aware of an impending seizure?  Yes  No

**Emergency medication(s)**

Name	Dose/Route	When to use
_____	_____	_____
_____	_____	_____

Child's Limitations or Special Considerations: \_\_\_\_\_

I understand that it is my responsibility to keep this information current.

Parent/guardian will be notified in event of a SEIZURE.

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# STEPS FOR A SEIZURE

\*\*\* Physician completes page two\*\*\*

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Action Plan for Seizure

### During Seizure Activity

1. STAY WITH THE CHILD
2. Keep calm –let seizure run its course
3. Call school nurse, or Volunteer Trained Employee(s), and the student's parent/guardian
4. DO NOT attempt to restrain the student or force objects between the teeth
5. Do not give any medication by mouth at this time.
6. Ease child to the floor if possible and remove objects from immediate area which may cause injury
7. Turn student on side to prevent aspiration or choking
8. Loosen tight clothing and place something soft and flat under the student's head
9. Time the seizure and observe the seizure pattern (such as number of seizures clustered together, nature of movements, and level of consciousness)
10. Determine if emergency anti-seizure medication is required, according to IHP and physician orders.

Have another adult remove/direct students from the area.

CALL 911 if child exhibits:

- a. Absence of breathing and/or pulse (Start CPR as needed).
- b. Seizure of \_\_\_\_\_ minutes or greater duration.
- c. Two or more consecutive seizures.
- d. No previous history of seizure activity.
- e. Continue unusually pale or bluish skin/lips or noisy breathing after the seizure has stopped.

Medication(s)	Dose	Route	When to use	Can medication be repeated?	How soon?
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Other instructions/comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ NOTIFY PARENT

\_\_\_\_ CALL 911 FOR EMERGENCY CARE IF SEIZURE LASTS LONGER THAN \_\_\_\_ MINUTES

\_\_\_\_ DIASTAT SHOULD BE ADMINISTERED IF SEIZURE LASTS LONGER THAN \_\_\_\_ MINUTES

NOTE: IF DIASTAT IS ADMINISTERED AT SCHOOL, EMS (911) WILL BE CALLED.

This child also has the following chronic illnesses/disabilities: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_