



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

Student Name: _____ DOB: _____

Action Plan for Seizure

During Seizure Activity

1. STAY WITH THE CHILD
2.
 - a. If falling or generalized jerking occurs, place child on floor.
 - b. Gently support head to side position and monitor breathing and pulse.
 - c. DO NOT restrain child. DO NOT try to place anything in child's mouth.
 - d. Protect child by moving items away that may cause injury—e.g. desks, chairs.
 - e. Loosen any tight clothing.
3. Have another adult remove/direct students from the area.
4. Time the seizure. Observe the pattern of the seizure and be prepared to describe it.
5. 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?

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: _____