PLYMOUTH JOINT SCHOOL DISTRICT – CONFIDENTIAL HEALTH INFORMATION
Student Health Services

School Year _____ **SEIZURE HEALTH ACTION PLAN**

Student Name _____

Date Of Birth _____ Grade _____ Grad Year _____
School _____ Teacher/ HR _____

PARENT / GUARDIAN EMERGENCY CONTACT INFORMATION:
Please provide phone numbers in order of where we can best reach you during the school day in case of emergency

Phone 1. _____ H/C/W Name/ Relationship _____
Phone 2. _____ H/C/W Name/ Relationship _____
Phone 3. _____ H/C/W Name/ Relationship _____
Phone 4. _____ H/C/W Name/ Relationship _____
Address for Health Plan updates:_____
Email for Health Plan updates: _____

Physician student sees for Seizures _____ Phone _____

SEIZURE INFORMATION

Seizure Type	Length	Frequency	Description

Receiving Treatment? Yes____ No____ If febrile seizures, temperature at which they occur _____ F
Seizure History: _____
_____
Significant Medical History: _____
_____
Seizure Triggers or Warning Signs: _____
_____
Students Reaction During Seizure: _____
_____
Likelihood and Frequency of Seizures During School Hours: _____
_____
Please specify any special considerations or concerns related to your child's seizures while at school, i.e., dietary, educational, behavior, recess, physical education, classroom precautions, school activities, sports, trips, etc.: (Note: Activity restrictions specified by physician need to be in writing and signed by the doctor.)
_____
_____
_____
Seizure Medication Given at **Home** (name, dose, frequency):
_____
_____

(SEE NEXT PAGE FOR EMERGENCY MEDICATION TO BE GIVEN AT SCHOOL)

NOTE: Parents are responsible for providing medication to be given during school. A Medication Authorization Form needs to be filled out and signed by a health care provider and parent annually. Medications must be in the original labeled container.

PLEASE COMPLETE AND SIGN NEXT PAGE ➔

Student Name _____

EMERGENCY ACTION PLAN FOR STAFF

NOTE: Care during a seizure is intended to keep the student safe, and when necessary, to stop a seizure. Most seizures stop on their own within 3 minutes.

Care and Comfort

- Stay calm and note the time that seizure began on the Seizure Flowsheet
- **Call Code Blue if you do not feel comfortable responding to a seizure**
- Retrieve student's emergency seizure medication, if at school
- Do not try to stop the movements. Keep the child safe
- Clear the area around the student of any hard, sharp or hot objects
- If walking around, gently lead your child from dangers, such as doors or stairways
- Place something flat and soft beneath the student's head
- Do not put anything in the mouth or between the teeth
- For a convulsive (tonic-clonic) seizure, gently roll the student onto one side and watch breathing closely
- Administer Emergency Medication as prescribed for seizure lasting longer than 5 minutes
- Stay with the student until the seizure is over and they can respond when you talk with them.
- Allow them to rest or go home if too fatigued to work successfully in the classroom
- Document time, response, medications, etc. on the Seizure Flowsheet
- Notify parent/guardian and notify school nurse
- Complete an Incident Report and Code Blue Report (if called)

Student has seizure emergency medication Yes _____ No _____ Location _____
Medication (Name/Dose/Route):

_____

Special Instruction _____

_____

Call 911

- **If seizures are convulsive (tonic-clonic) seizure lasts longer than 5 minutes**
- **If DiaStat or other emergency medication was administered and seizure continues**
- **If seizures are consecutive (occurring one after the other)**
- **If student has a first time seizure**
- **If student appears bluish or gray after the seizure ends or has difficulty breathing**
- **If student was injured during the seizure or the seizure occurred in water**
- **If student might be pregnant or has Diabetes**

This plan and medication will be used in case of emergency and accompany student off school property. This information may be shared with the classroom teacher(s), administrators, aides, bus driver, and other appropriate school personnel with a need to know.

Parent/Guardian Signature: _____ Date _____

School Nurse: _____ Sara Stout, RN or Anne Nelson, RN

Health Care Provider Signature: _____ Date _____
(if necessary)