EVANSVILLE-VANDERBURGH SCHOOL CORPORATION
HEALTH SERVICES
PLAN OF CARE - SEIZURE

Name: _____
Last Name First MI

Grade_____Age_____

School _____

Parent/Guardian Name_____
Phone (H)_____ Phone (WK)_____
Address_____

Parent/Guardian Name_____
Phone (H)_____ Phone (WK)_____
Address_____

Emergency Phone Contact #1_____
Name

_____ _____
Relationship Phone

Emergency Phone Contact #2_____
Name

_____ _____
Relationship Phone

Physician Student Sees for Seizure:

_____ _____
Physician Phone

Other Physician

_____ _____
Physician Phone

ALLERGIES: Food, Medication, etc.

_____

_____

DIET: Address any dietary restrictions or special hydration needs

_____

_____

DAILY SEIZURE MANAGEMENT PLAN: Check each that applies to the student. Identify the things which start a seizure.

☐ Exercise ☐ Other _____

Comments:_____

_____

ACTIVITY RESTRICTIONS: Please address playground activity, sports

_____

_____

SAFETY PRECAUTIONS:Protective helmet, etc

_____

_____ (over)

MEDICATIONS: Please address side effects staff need to observe for, or that might interfere with learning.

Name of Medication	Dosage & Frequency	Possible Side Effects

AURA (Present prior to seizure) ☐ Yes ☐ No
Please describe if present i.e. visual, auditory, olfactory

_____

_____

EMERGENCY PLAN:
Emergency action is necessary when the student has symptoms such as_____,_____
_____. and/or _____

Steps to take during a seizure episode:

1. Contact parent if _____

_____

2. Seek emergency Medical care - call EMS 911 immediately if student has any of the following:

- Absence of breathing and/or pulse
- Seizure of 5 minutes or greater duration
- Two or more consecutive (without a period of consciousness between) seizures which total 5 minutes or greater
- Continued unusually pale or bluish skin/lips or noisy breathing after the seizure has stopped

Comments/special instructions:

_____

_____

_____

_____

_____

_____ _____
Physician Signature Date

March 1999