GRIFFIN-SPALDING COUNTY SCHOOLS
SEIZURE HEALTH CARE PLAN
School Year: _____

Student's Name: _____ D.O.B.: _____ Teacher: _____
School: _____ Grade/Team: _____

Parent/Guardian's Name: _____ Home Phone: _____ Other: _____
Mother's Work #: _____ Father's Work #: _____

Emergency Contact Name: _____ Relationship: _____
Home Phone: _____ Other: _____

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

Student's reaction to seizure(s): _____

Basic First Aid: Care & Comfort

Basic Seizure First Aid
- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic (grand mal) seizure:
- Protect head
- Keep airway open/watch breathing
- Turn child on side

Does student need to leave the classroom after a seizure?
☐ Yes ☐ No

If YES, describe process for returning student to classroom.
_____

Emergency Response

A seizure is generally considered an *EMERGENCY* when:
- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

A "seizure emergency' for this student is defined as:
_____

Seizure Emergency Protocol
(Check all that apply and clarify below)

☐ Call 911 for transport to _____
☐ Notify parent or emergency contact
☐ Administer emergency medications as indicated below
☐ Notify Doctor

Treatment Protocol During School Hours (include daily and emergency medications)

Emergency Meds	*Medication*	*Dosage & Time of Day Given*	*Common Side Effects & Special Instructions*

Does student have a Vagus Nerve Stimulator? ☐ Yes ☐ No If YES, describe magnet use

_____

_____

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

_____

_____

_____

Physician's Signature: _____ **Date:** _____

Physician's Name: _____ **Phone Number:** _____

I, (parent/guardian), _____, *hereby authorize (Healthcare Provider)* _____, *who has attended to my child,* _____, *to furnish to the (School Nurse Supervisor or designee), any medical information and/or copies of records pertaining to my child's Seizures and for this information to be shared with pertinent school staff. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act (HIPPA), disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Griffin-Spalding County Schools. This authorization expires as of the last day of the school year.*

Parent/Guardian's Signature: _____ **Date:** _____

School Nurse/Administrator: _____ **Date:** _____

Seizure Observation Record

Student's Name: _____

Date & Time					
Seizure Length					
Pre-Seizure Observation (Briefly list behaviors, triggering events, activities)					
Conscious (yes, no, altered)					
Injuries (briefly describe)					
Muscle Tone/Body Movements	Rigid/clenching				
	Limp				
	Fell down				
	Rocking				
	Wandering around				
	Whole body jerking				
Extremity Movements	(R) arm jerking				
	(L) arm jerking				
	(R) leg jerking				
	(L) leg jerking				
	Random Movement				
Color	Bluish				
	Pale				
	Flushed				
Eyes	Pupils dilated				
	Turned (R or L)				
	Rolled up				
	Staring or blinking (clarify)				
	Closed				
Mouth	Salivating				
	Chewing				
	Lip-smacking				
Verbal sounds-describe (gagging, talking, throat clearing, etc)					
Breathing-describe (normal, labored, stopped, noisy)					
Incontinent (urine or feces)					
Post-Seizure Observation	Confused				
	Sleepy/tired				
	Headache				
	Slurred speech				
	Other				
Length to orientation					
Parents notified? (note time of call)					
EMS called? (note call and arrival time)					
Observer's name					