Timberlake Christian Schools

SEIZURE EMERGENCY HEALTH CARE ACTION PLAN

Student's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____ Cell: _____

Treating Physician: _____ Phone: _____

TO BE COMPLETED BY PHYSICIAN

Significant Medical History: _____

_____

_____

_____

Does Student Have Emergency Medication? ☐ Yes ☐ No

Does Student have a shunt? ☐ Yes ☐ No Is Student Diabetic? ☐ Yes ☐ No

Special Considerations & Safety Precautions (regarding school activities, sports, field trips, etc.): _____

_____

SEIZURE INFORMATION

Seizure Type	Length	Frequency	Description

Seizure Triggers or Warning Signs: _____

Student's reaction to seizure: _____

BASIC FIRST AID: Care and Comfort

(Please describe basic first aid procedures): _____

_____

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

If yes, describe process for returning to classroom: _____

_____

EMERGENCY RESPONSE:

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

_____

Seizure Emergency Protocol: (check all that apply)

___ Call 911 or emergency contact

___ Notifiy parent or emergency contact

___ Administer other medications as indicated below:

___ Other: _____

Basic Seizure First Aid:

- **Stay calm**
- **Track time and description of seizure**
- **Keep student safe**
- **Do not restrain**
- **Do not put anything in mouth**
- **Stay with student until fully conscious**
- **Record seizure in health care record**

For Tonic-Clonic Seizure (Grand Mal)

- **Protect head**
- **Keep airway open/watch breathing**
- **Turn student on side**

A seizure is generally consider an Emergency when:

- **A convulsion (tonic-clonic) seizure lasts longer than 5 minutes**
- **Student had repeated seizures without regaining consciousness**
- **Student has a first time seizure**
- **Student is injured or has diabetes**
- **Student has breathing difficulties**
- **Student has seizure in water**

TREATMENT PROTOCOL DURING SCHOOL HOURS: (include daily and emergency medications)

Daily Medication	Dosage & Time of Day Given	Common Side Effects and Special Instructions

EMERGENCY/RESCUE MEDICATION:

_____

Does student have Vagus Nerve Stimulator (VNS) _□ Yes □ No

If yes, describe magnet use: _____

MEDICATIONS

Name	Dose	Route	Time

I have prescribed medications, emergency procedures, outlined and reviewed the plan of care for this student. The plan of care is in accordance with the student's medical management.

For School Year 20___ through 20___

Physician Signature: _____ Date: _____

PARENTAL CONSENT:

I give permission for school personnel to follow the Seizure Emergency Health Care Plan and administer the prescribed medications in accordance with the above instructions. I understand that I am responsible for providing the school with the prescribed medication needed by my child. I acknowledge that I have read, understand, and do now support the Seizure Emergency Health Care Plan as outlined above. I agree to allow information on this Seizure Emergency Health Care Plan to be shared with the adults responsible for my child's care. I hereby release Timberlake Christian Schools from any claims or liability connected with such reliance.

Signature of Parent/Guardian: _____ Date: _____

Note: a new Seizure Emergency Health Care Plan is required on an annual basisand a revision with any significant changes in the student's health status.