|  |  |  |
| --- | --- | --- |
| Description: Description: Description: Description: Description: C:\Users\stearnsr\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\RI03ZLPU\ISDLogo1.jpg | **SEIZURE** **Emergency Care Plan/504**  |   |
| Student Name:  |    |   |
| DOB:  |   | Grade:  |   |
| School:  |   | Year:  |   |
| Teacher:  |   |   |    |
| Transportation:  | Walk    | Car   | Bus  |  |  |
| Address: |   |  Primary Phone:   |   |
| Guardian 1 Name:  |   |  Cell:  |   |
| Work:  |   |
| Guardian 2 Name:  |  | Cell :  |   |
| Work: |   |
| Physician:  |   | Phone:  |   |
| Daily Medication:  |   | Allergies:  |   |
| **Vagus Nerve Stimulator**  | Yes 🗆 | No 🗆 |  |
| **Type of Seizures:** (Enter diagnosis here) |
| Seizure History  |  |
| Triggers  |  |
| Special Precautions  |  |

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| **EMERGENCY INTERVENTION**  |
| **Seizure Observed**  | **Immediate Response**  |
| **Grand Mal (Tonic-Clonic)** *Muscles tense, body rigid, followed by a temporary loss of consciousness and shaking of entire body. Usually lasts 2-5 minutes* Additional Student Information: |

|  |  |
| --- | --- |
| **'** | **Follow Licensed Healthcare Provider order for when to call 911. Notify Parents.**  |
| **'** | Stay calm & track time  |
| **'** | Keep child safe, Clear area, Protect head  |
| **'** | Do not restrain the student  |
| **'** | Do not put anything in mouth, turn on side  |
| **'** | Keep airway open/watch breathing  |
| **'** | Stay with child until fully conscious  |
| **'** | Document Seizure  |

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| **Seizure is an Emergency When:**  |
| **'**  | Convulsive (Tonic-Clonic) seizure lasts longer than 5 min  |
| **'**  | 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  |
| **'**  | Diastat has been administered  |

 | **Call 911** **Call Parents**  |
| Additional Student Information: |
|  |

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| **CONFIDENTIAL INFORMATION**  | page 1  | **SHRED PRIOR TO DISCARD**  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Student Name:  |  | **SEIZURE ECP/504**  | Age:  |  | Grad Year:  |  |
| **EMERGENCY INTERVENTION** -CONTINUED |
| **Petit Mal:** *Staring spells. May drop object(s) or may stumble momentarily.Usually lasts 2-5 minutes* **Psychomotor Seizure:** *Some degree of impairment of consciousness may be accompanied by automatic movements like lip smacking, roaming, and* ***non-goal oriented activity*** *. May last several seconds or minutes*.  |

|  |  |
| --- | --- |
| **'** | Stay calm and track time  |
| **'** | No first aid needed unless seizure becomes convulsive or student is injured  |
| **'** | Keep student safe  |
| **'** | Stay with student until seizure ends  |
| **'** | Notify the parent  |
| **'**  | Document Seizure  |

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Custom Defaults

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| **Section 504**  |
|  |  | **I** **acknowledge the evaluation and accommodation plan here provided, and have received a copy of Section 504 Parent/Student rights.**  |
| **EMERGENCY CONTACTS**  |
|  |  | **Name**  |  | **Phone**  |  | **Relationship**  |
|  | 1. |  |  |  |  |  |
|  | 2. |  |  |  |  |  |
|  | 3. |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Parent Signature:  |  | Date:  |  |
| School Nurse :  |  | Date:  |  |
| **A copy of the Health Care Plan will be kept in the school office and copies will be given to all District staff members involved with the student**.  |
| **CONFIDENTIAL INFORMATION**  | page 2  | **SHRED PRIOR TO DISCARD**  |