

## ***Seizure Care Plan for Desoto County Schools***

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_ Teacher: \_\_\_\_\_

Parent/Guardian's name: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

Parent/Guardian's name: \_\_\_\_\_ Daytime phone: \_\_\_\_\_

Other emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Treating Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

***Seizure triggers or warning signs:*** \_\_\_\_\_

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### ***Basic First Aid for Seizures:***

- *Assist the student to the floor, if needed*
- *DO NOT put anything in the mouth*
- *DO NOT restrain*
- *Clear area to protect student from injury (place something soft under their head)*
- *Keep airway open/ watch breathing*
- *Turn student on their side*
- *Start CPR if necessary*
- *Start a written record of the seizure behavior and treatment, including length of seizure activity.*
- *Give emergency medication as ordered:* \_\_\_\_\_  
\_\_\_\_\_
- *Notify parents*

### ***Call 911 if:***

- *Seizure activity is different from "usual" seizure activity*
- *Student's breathing is affected*
- *Seizure last longer than 5 minutes*
- *Student fails to regain consciousness after seizure activity has stopped.*
- *Student's usual seizure activity includes:* \_\_\_\_\_  
\_\_\_\_\_
- *If the seizure activity last longer than \_\_\_\_ minutes, 911 should be called.  
(Note: 911 will be called by school staff for any seizure activity lasting longer than 5 minutes unless otherwise instructed by doctor.)*

**After the seizure:**

- *Permit the student to rest*
- *Continue to document the episode*
- *Monitor for second episode*
- *Monitor for confusion or lack of consciousness.*

**Other special instructions for seizures:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Does the student have a Vagus Nerve Stimulator? \_\_\_ Yes \_\_\_ NO**

**If yes, instructions for use:** \_\_\_\_\_

\_\_\_\_\_

**Special considerations and precautions regarding school activities, sports, field trips, etc.** \_\_\_\_\_

\_\_\_\_\_

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If I cannot be reached by phone and my child does not respond to the treatment, I give my permission for school staff to call the physician listed above and to follow his/her instructions. If the physician orders hospitalization or my child is exhibiting symptoms of a medical emergency, my child will be transported to the nearest hospital. I also understand that school staff can and will be informed of my child's health concerns in order to provide safe, appropriate care.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**List of current medications:**

1. \_\_\_\_\_ Dose \_\_\_\_\_ Times given \_\_\_\_\_

2. \_\_\_\_\_ Dose \_\_\_\_\_ Times given \_\_\_\_\_

3. \_\_\_\_\_ Dose \_\_\_\_\_ Times given \_\_\_\_\_