Stewartville School District #534

(insert picture)

SEIZURE EMERGENCY CARE PLAN

Date of Plan: / / This plan is valid for the current school year: 20 ___

STUDENT INFORMATION

Name: DOB: / / Grade: School:

SEIZURE INFORMATION

SEIZURE TYPE	LENGTH	FREQUENCY	DESCRIPTION:

Seizure triggers or warning signs:

Student's response after a seizure:

BASIC FIRST AID: CARE & COMFORT

* Track duration of seizure.
* Always stay with the student and protect their head.
* Move the student to the floor if possible and clear area of hazards.
* Do not restrain or put anything in the student's mouth.

SEIZURE EMERGENCY PROTOCOL

Check all that apply:

- ☐ **Contact Health Services Staff at ___________**
- ☐ **Call 911 if seizure lasts longer than:__________**
- ☐ **Administer emergency medications as indicated below**
- ☐ **Notify parent or emergency contact**
- ☐ **Other:________________________________**

A SEIZURE IS GENERALLY CONSIDERED AN EMERGENCY WHEN:

* **Convulsive generalized 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**

CONTACT INFORMATION

Parent/Guardian:	Phone:	Phone (Cell):
Parent/Guardian:	Phone:	Phone (Cell):
Emergency Contact:	Phone:	Phone (Cell):

Preferred Hospital:

PHYSICIAN'S AUTHORIZATION FOR MEDICATION ADMINISTRATION

EMERGENCY MEDICATION	DOSAGE	TIME	SPECIAL INSTRUCTIONS:

SPECIAL CONSIDERATIONS & PRECAUTIONS:

Physician's Signature X: **Date: / /**

Physician's (Printed Name): Phone:

Clinic: Fax:

AUTHORIZATION FOR STAFF ADMINISTRATION OF MEDICATION

I understand that trained school personnel will follow the Anaphylaxis Emergency Care Plan as completed by my child's physician, school nurse and myself. Further, undert the delegation of the LSN/RN, I hereby give my permission that trained school personnel can administer this emergency medication in the absence of a school nurse or if my child is away from the school on a field trip or other school activity.

Parent/Guardian signature: **Date: / /**

Health Services Staff signature: **Date: / /**