Seizure Management Plan

TO BE COMPLETED BY PARENT(S):

Date:________________________

Student ________________________________  Grade ___________  Teacher ________________________________

Mother’s Name & Day Time Phone ________________________________  Father’s Name & Day Time Phone ________________________________

Physician treating condition ________________________________  Address ________________________________

Physician Phone ________________________________  Fax ________________________________

TYPE(S) OF SEIZURE: ______________________________________________________________

DESCRIPTION OF TYPICAL SEIZURE

Body involvement: ______________________________________________________________

Average Duration: ______________________________________________________________

Frequency (daily, weekly, other): __________________________________________________

Usual times of day: ______________________________________________________________

Behavior/warning prior to seizure: __________________________________________________

Student response to seizure: ______________________________________________________

Care needed during seizure, aside from typical precautions: ______________________________

Care needed after seizure:

☐ Rest in nurse’s office

☐ Other: _______________________________________________________________________

Daily Medication

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<th>MEDICATION</th>
<th>DOSE/ROUTE</th>
<th>TIME</th>
<th>POSSIBLE SIDE EFFECTS</th>
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Physical Education/Team Sports:

- Full participation, no limitations
- Participation with the following modifications: ________________________________

Emergency Intervention:

- If seizure lasts longer than _______ minutes, then ____________________________
- If _________ or more seizures occur in a row, then ____________________________
- If seizure occurs on the bus, then ____________________________
- Other: ____________________________

Instructions:

- Seizure Observation record (as needed) to be completed by staff during school and shared with parents on a _______ interval.
  (weekly/Monthly)
- If school is unable to reach parents in an emergency, permission is granted to contact physician listed above.
- I/We agree to release this information to the following staff, with the expectation that confidentiality will be respected at all times:
  - Nurse
  - Teachers
  - LST (counselor, social worker)
  - After school caregivers/coaches
  - Bus Personnel
  - Other: ____________________________

Additional Comments: _________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

_________________________________________            ______________
Parent(s) Signature                               Date

_________________________________________            ______________
Physician(s) Signature                           Date

Return this form to: Vernon Hills High School
Nurse’s Office
145 N. Lakeview Parkway
Vernon Hills, IL 6061
Ph: 847-932-2040 Fax: 847-932-2188