Skokie School District 68

Our mission is to develop children who are confident and creative learners. We provide a rigorous curriculum and a supportive school environment that promotes high achievement, encourages personal growth, and meets the unique needs of each child.

SPECIAL SERVICES DEPARTMENT
9310 North Kenton Avenue
Skokie, Illinois 60076-1338
Telephone: 847/568-7504
Fax: 847/568-7599
internet: www.skokie68.org
Email - ibalici@skokie68.org
Andreea Balici, Health Services Coordinator
Crissy Mombela , Director of Special Services

EMERGENCY HEALTH CARE PLAN - SEIZURE DISORDER

Effective School Year: 20 _____ to 20_____ Today's Date:_____

Student's Name: _____ Date of Birth: _____ Grade: _____

Physician's name and phone #: _____

Parent/Guardian #1 name and #: _____

Parent/Guardian #2 name and #: _____

CONVULSIVE SEIZURE DISORDER

Description: sudden disturbance in the electrical activity in the brain. This disturbance affects the whole brain and results in loss of consciousness.

IF YOU SEE THIS:	DO THIS:
• May begin with an aura or cry • Will lose consciousness and fall • Body will stiffen, followed by arms, legs and body showing uncoordinated, muscular jerking movements • Shallow breathing • Skin pale or bluish	1. Notify school nurse / health clerk 2. help the student to the floor if falling and position on his/her side 3. clear the area around the student of objects that might cause injury 4. time the seizure 5. DO NOT RESTRAIN other than to prevent injury 6. DO NOT put anything in the mouth **If any seizure lasts more than 5 minutes, if more than one seizure occurs, if there is absence of breathing after muscle jerks subside, or if there is no previous history of seizures:** ➢ **CALL 911** ➢ **CHECK AIRWAY, BREATHING, CIRCULATION AND INITIATE STEPS OF CPR AS NEEDED** 7. Stay with student to offer reassurance when consciousness returns 8. let the student rest 9. school nurse or health clerk will notify parent/principal 10. document in powerschool

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(Continuation of convulsive seizure emergency action plan)

TO BE REVIEWED AND SIGNED BY PARENT/GUARDIAN

I give permission to the school nurse/health clerk and other designated staff members of District 68 to perform and carry out the emergency care plan as outlined by this emergency health care plan. I also consent to the release of the information contained in this emergency health care plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____ _____
Parent Signature Date

TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER UPON REVIEW AND APPROVAL

Medications student takes at home: _____

Medication to be taken at school for this condition: _____

Other medical information: _____

_____

_____ _____
Physician signature Date

This form shall be effective for the current school year only, and must be renewed each subsequent school year.