KENSTON SCHOOLS

To be Completed by Health Care Provider and Signed by Parent

SEIZURE EMERGENCY CARE PLAN

Our records show that you have indicated that your child has a seizure disorder. In order to care for your child at school, we are requesting that you complete the following form.

Name: _____ Grade: _____ School:_____
Medication taken:_____ How often: _____
Description of last seizure and when it occurred:
_____
Health Care Provider Treating Student:_____ Phone: _____

To provide assistance to a student experiencing a seizure:

If You See This

Description of Seizure:_____
Usual duration of Seizure: _____
Triggers which start a Seizure: _____
Possible Seizure signs: _____
Other relevant information: _____

Do This

- Help student to the floor and place on side and stay calm
- Clear objects out of the way and place something soft and flat under the student's head
- Loosen tight clothing and monitor the student's breathing
- Do not try to stop seizure or hold the student down and don't put anything in student's mouth
- Time the seizure
- Stay with the student until the seizure ends, then allow the student to rest
- Re-orient the student and notify the parents and document for student's file
- Other: _____

(Indicate all that apply)

CALL 911 if…

1. Absence of breathing and/or pulse
2. Duration of seizure is 5 minutes or longer
3. Two or more consecutive seizures occur which total 5 minutes or longer
4. Student continues to be unusually pale, has bluish lips and/or skin, or has noisy breathing after the seizure has stopped.

I authorize school personnel to follow the Seizure Emergency Plan as described above.

_____ _____
Health Care Provider Signature Date

I give consent for school authorities to follow the above plan for the safety and welfare of my child. I give consent to communicate with the health care provider, as necessary.

_____ _____
Parent/Guardian Signature Date