West Bend School District
Seizure Healthcare Plan

****the information in this document is confidential**

Name _____ School Year _____
Birthdate _____ School _____
Parent _____ Teacher _____
Address _____ Physician _____
_____ Phone (M.D.) _____
Home Phone _____
Dad's Work # _____ File number
Mom's Work # _____

Check below all that apply.

My Child's Seizure Includes:	Do This
Absence (petit mal) seizure, brief staring spell	_____Do nothing _____Report to parents: Daily Weekly (circle one)
_____**Partial seizure**: may walk around, perform aimless activities_____ _____ _____ _____	_____Do not restrain _____Report to parent immediately or sent note home to parent (circle one) _____Allow _____ minutes to rest and re-orient self return to class _____Other_____ _____ _____
_____**Convulsive seizure**: _____Sudden cry, fall, rigidity, followed by muscle jerks, saliva on lips, bluish skin color _____Possible loss of bladder or bowel control _____Usually lasts _____ minutes _____Some confusion, headache, and fatigue followed by full return to consciousness _____Other_____ _____ _____	Follow General First Aid guidelines: _____Notify parents: immediately or note home (circle one) Protect from nearby hazards Place folded towel under head Do not attempt to put anything in mouth or try To restrain in any way. Treat injuries that may have occurred. Allow _____minutes to rest and re-orient Self/return to class. If single seizure lasts more than _____ Minutes, call parents/911 If multiple seizure occur call parents/911

Medications:_____

_____

_____

Comments:_____

_____

_____

continued on other side

SEIZURE DISORDER

How long has your child had seizures?_____

How do other illnesses affect your child's seizure control?_____
_____

Are there any warning and/or behavioral changes before the seizure?_____
_____
_____

Please describe what happens during a seizure:_____
_____
_____

How long does a seizure last?_____
_____

How often does your child have seizures?_____
_____

Date of last seizure?_____

Will your child need to take medication during school hours? _____ Yes _____ NO

IF YES, YOU MUST HAVE A BLUE MEDICATION CARD SIGNED BY YOUR CHILD'S DOCTOR ON FILE FOR <u>THIS</u> SCHOOL YEAR.

Check any special considerations related to your child's epilepsy while at school and describe them briefly.

_____Educational concerns:_____
_____

_____Behavioral/Emotional concerns:_____
_____

_____Physical Education/Recess Precautions:_____
_____

_____Special transportation to and from school:_____
_____

How often does your child see the doctor regarding seizures?_____
Date of last appointment?_____

_____ _____
Parent Signature Date

_____ _____
School Nurse Signature Date of Review