SEIZURE EMERGENCY CARE PLAN 2023-2024 SCHOOL YEAR
GREENFIELD-CENTRAL COMMUNITY SCHOOL CORPORATION

Student's Name: _____ Date of Birth: _____

EMERGENCY CONTACTS

Name	Relationship	Telephone
1.		
2.		

EMERGENCY PLAN OF ACTION

1. If the student exhibits any signs of a seizure, notify the clinic immediately. Note the time the seizure began.
2. Protect the student from injury during the seizure. Remove any hard or sharp objects from the immediate area. Do not attempt to restrain the student's movements. Do not place any object into the student's mouth. If available, place a blanket, jacket, pillow, etc., under the student's head.
3. If student begins to vomit, turn him/her on their side.
4. Do not leave the student alone. Evacuate students, visitors and unnecessary staff from the area.
5. Following the seizure, document what happened before, during and after the seizure, time seizure began, length of seizure, and what seizure activity was present.
6. Notify parents of the seizure activity.
7. Call 911 immediately if any of the following are present:
    a. Absence of breathing and/or pulse – begin CPR for respiratory or cardiac arrest
    b. Seizure lasts five minutes or greater
    c. Two or more consecutive seizures
    d. Any difficulty breathing
    e. Student continues to have pale or bluish skin/lips or noisy breathing after the seizure has stopped

SEIZURE INFORMATION – Completed by Healthcare Provider

Type of seizures:

□ Complex Partial □ Febrile Seizure □ Absence □ Generalized tonic-clonic □ Other _____

What does the seizure look like and how long does it usually last? _____

_____

Seizure triggers or warning signs: _____

Are there any activities this student may not participate in while at school?

□ No, student may fully participate in all activities. □ Yes, student should not participate in (please list excluded activities): _____

Please list daily controller medications student takes at home for seizure prevention, including name, dose and frequency:

_____

*****THIS IS A 2-SIDED FORM - BOTH SIDES MUST BE COMPLETED FOR PLAN TO BE IMPLEMENTED.*****

Please list rescue medications prescribed to the student (Form 5330F1 must also be completed for administration at school), including name, dose and route:

_____

Does the student have a Vagus Nerve Stimulator (VNS)? □ No □ Yes ***If yes, follow these instructions for use of VNS if student is showing symptoms of a seizure:***

_____

_____

Healthcare Provider's Signature: _____ Date: _____

HCP's Printed Name: _____ Telephone Number: _____

SEIZURE INFORMATION – Completed by Parent/Guardian

In addition to the above instructions from the HCP, I wish to communicate the following information to school personnel regarding my student:

_____

As the parent/guardian of a student with seizures, I understand I should inform bus drivers, coaches, extra-curricular sponsors, tutors, etc., of my student's condition. I agree with and wish to implement this emergency care plan for my student. My student understands the importance of reporting symptoms immediately to the school health assistant. I hereby give permission for the exchange of medical information between the school nurses, health assistants, school principal, and the HCP listed above. I also give permission for clinic personnel to share this medical information with school staff as needed to help protect my student's safety and well-being.

Parent/Guardian's Signature: _____ Date: _____

Printed Name: _____

TO BE COMPLETED BY SCHOOL PERSONNEL

Date ECP received by clinic personnel: _____

□ ECP reviewed by clinic personnel, PowerSchool medical alert updated, and paper copy of ECP forwarded to appropriate nurse for development of the health care plan.

_____ _____

Date Signature

Notes from clinic personnel regarding this plan (if necessary):