School District of Manawa
"Students Choosing to Excel, Realizing Their Strengths"
800 Beech Street | Manawa, WI 54949 | (920) 596-2525
District Fax (920) 596-5308 | Elementary Fax (920) 596-5339 | Jr./Sr. High Fax (920) 596-2655

SEIZURE MANAGAEMENT PLAN

School Year _____

Student _____ Birth Date ___/___/___ Age _____ Grade _____

School Attending:
☐ Elementary School • Phone (920) 596-5700 • Fax (920) 596-5339 Teacher/Advisor _____
☐ Little Wolf Middle/High School • Phone (920) 596-5800 • Fax (920) 596-2655 Teacher/Advisor _____

PARENT • GUARDIAN • EMERGENCY CONTACT

Parent / Guardian 1
Name _____ Relationship _____ Phone ( ) -
Workplace _____ Work Phone ( ) -

Parent / Guardian 2
Name _____ Relationship _____ Phone ( ) -
Workplace _____ Work Phone ( ) -

Emergency Contact 3
Name _____ Relationship _____ Phone ( ) -
Workplace _____ Work Phone ( ) -

MEDICAL PROVIDERS

Primary Care Physician _____ Phone ( ) -
Neurologist _____ Phone ( ) -
Hospital _____ Phone ( ) -

SEIZURE DESCRIPTION

Seizure Type _____
What Triggers Seizure(s) _____
Warning Signs Typically Exhibited _____
Average Length of Seizure Activity _____ Average Time Until Student Resumes Regular Activities _____
Student's Behavior After Seizure _____
Care After Seizure _____
Student has a Vagus Nerve Stimulator (VNS) ☐ No ☐ Yes If yes, explain use of magnet. _____
List any accommodations, considerations, or precautions that need to be made.

DAILY MEDICATION *(List Emergency Medications on Page 2)*

Name	Administered at	Dose	Route	Time of Day	Start Date	End Date
	☐ Home ☐ School					
	☐ Home ☐ School					
	☐ Home ☐ School					

Negative Side Effects _____

Student _____ Seizure Management Plan for School Year _____

BASIC SEIZURE FIRST AID

- Stay calm AND Track Time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

CONVULSIVE SEIZURES

- Protect head
- Loosen restrictive clothing
- Keep airway open/
- Watch breathing
- Turn child on side

BASIC FIRST AID CARE AND COMFORT

Describe additional basic first aid procedures

_____

_____

_____

_____

A SEIZURE IS AN EMERGENCY WHEN:

- Student has repeated seizures without regaining consciousness
- Convulsive seizure lasts longer than 5 minutes
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

EMERGENCY RESPONSE

1 Call 911

2 Administer Emergency Medication

3 Notify Parent

4 Other, specify _____

EMERGENCY MEDICATION

Name	Dose	Route	Reason to be given

Negative Side Effects _____

CONSENT FOR MANAGEMENT OF HEALTH CONDITION AT SCHOOL OR SCHOOL-SPONSORED ACTIVITIES

I, the parent/legal guardian, of the above-named student, grant permission for designated school staff to follow this action plan and request that this action plan be used to guide the care of my child in case of a health care emergency. Further, I agree to:

1. Provide necessary supplies & equipment in original pharmacy labelled container and/or manufacturer's packaging and within the expiration date.
2. Authorize the administration of medication and treatment of health condition per this plan.
3. Notify school staff or school district nurse; complete new forms for any changes in the student's health status, orders from the student's health care provider, etc.
4. Ensure this form is signed by the appropriate medical provider who manages the medical condition, prescription and/or in doses that exceed the manufacturer's recommended dosages for non-prescription medications or over-the-counter (OTC) medications.
5. Authorize designated school staff or school nurse to communicate directly with primary care provider or specialist regarding health condition & medication.
6. Authorize school staff interacting directly with my child to be informed about this health care plan.
7. Submit new forms annually if the health condition and/or need for medication still exists or inform the school that the condition no longer exists and provide documentation of such, if deemed necessary.
8. Hold without liability the School District of Manawa, its' Board of Education, administration, and all employees and agents who are acting within the scope of their duties in all claims arising from the administration of this medication and treatment of this health condition, to policy at school.

Parent/Legal Guardian Signature _____ Date _____

Student signature is required if student is 18 years old or attaining 18 years old during the school year

Student Signature _____

Date _____

PRIMARY CARE PHYSICIAN INFORMATION / SIGNATURE

Print Name _____ Phone _____

Medical Facility _____ Fax _____

Address _____ Physician Signature _____

City, State, Zip _____ Date _____