# School District of Manawa

Student Health Services
District Nurse Olivia Koehn RN, BSN|(920) 596-5841
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## Seizure Management Plan 2017/2018

Student Name ______________________________ Date of Birth ________________

School ________________ Teacher ________________

Student ID# ______________ Grade ____________

Home Street Address ________________________________

City ________________ State ________ Zip Code __________

Parent/Guardian Name ______________________

Parent/Guardian Name ______________________

**Please keep all parent/guardian and emergency contact information current with school office staff. In the event of a seizure emergency we will attempt to contact parents/guardians followed by emergency contacts in the order on file.**

**Will your child take seizure medication at school?** ☐ **YES** ☐ **NO**

If a prescription seizure medication will be taken daily, a prescription medication form will need to be filled out and kept on file at school in addition to this form. If only emergency medication will be taken for seizures at school, this form has a box for that information and no additional form is necessary.

What triggers your child's seizures?

________________________________________________

List warning signs of a seizure your child typically exhibits:

________________________________________________

Describe the behavior of your child after a seizure:

________________________________________________

Does student have a Vagus Nerve Stimulator (VNS)? ☐ YES ☐ NO

If yes, please explain the use of magnet. ______________________________

Please list any other accommodations, considerations, or precautions that need to be made.

________________________________________________

### Seizure Information

| Seizure Type | Length of time | Frequency | Description |
|---|---|---|---|
| | | | |
| | | | |

-Turn Over-

**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

**For Convulsive seizures:**

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

**A seizure is generally considered 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

**Basic First Aid: Care and Comfort**

Please describe additional basic first aid procedures: ________________________
______________________________________________________________________
______________________________________________________________________

**EMERGENCY Response**

1. Call 911
2. Administer Emergency Medications as listed in plan
3. Notify Parent
4. Other ____________________________________________________

**Treatment Protocol for EMERGENCY Seizure Medications:**

| Medication Name | Dose (amount) | Frequency/ Timing | Route | Special Instructions |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Parent/Student consent for management of health condition while at school or other school-related activities**

I, the parent/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. Furthermore, I agree to:

1. Provide the necessary supplies and equipment.
2. Notify the school staff or school district nurse of any changes in the student's health status.
3. Notify the school staff and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
5. School staff interacting directly with my child may be informed about this health care plan.
6. Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.
7. 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/Guardian Signature__________________________________________ Date______________________

Student Signature (if the student is 18 years old or will turn 18 during the 2017/2018 school year)

_____________________________________________________________________ Date______________________

**Physician Information**

Print Name of Provider____________________________________ Institution Name ____________________________________

Phone Number______________________________________________ Fax Number ________________________________

Address _________________________________________________________________________________________

Signature of Provider________________________________________________ Date___________________________

Revised 2/2017