

*****PRIOR LAKE-SAVAGE ARE SCHOOLS HEALTH SERVICES***
SEIZURE HISTORY / IHP / EMERGENCY ACTION PLAN**

Student Name: _____ Grade: _____

DOB: _____ Sex: _____ Room Number: _____ MedicAlert ID? **Y N**

Parent / Guardian Name: _____

Phone: (H) _____ (W) _____ (CELL) _____

Parent / Guardian Name: _____

Phone: (H) _____ (W) _____ (CELL) _____

Physician Name: _____ Phone: _____

Neurologist: _____ Clinic: _____

Hospital (In Case of Emergency): _____

Type(s) of Seizure Disorder

_____ Generalized (Tonic-Clonic) _____ Partial (Local)
_____ Complex (Psychomotor) _____ Absence (Petit Mal)
_____ Other _____

Date of last seizure: _____

Does your student have a aura (warning sign) before the seizure? ___ Yes ___ No

Describe the aura:

Describe a typical seizure, including triggers and behavior after seizure:

Usual duration:

Frequency of seizures and likelihood of having one at school:

Seizure History:

Age at diagnosis: _____

Has your student ever been hospitalized or seizures? ___ Yes ___ No

Date of last hospitalization for seizure: _____

Has your student had an EEG? ___ Yes ___ No Date: _____

Results of EEG:

Current Treatment:

Medications (state name, dose and times given): *med form required if needed at school

Side effects of medication:

Length of time on current medications:

Please list any needed classroom/Phy Ed restrictions needed for _____

First Aid and Immediate Treatment (for tonic-clonic seizure):

- Help student lie down and cushion head
- Remove glasses
- Loosen tight clothing
- Clear area of sharp or hard objects
- Turn student to side to prevent aspiration
- Monitor length of seizure and record (on flow sheet, if avail.)
- Don't put anything in student's mouth
- Don't attempt to give student anything to drink
- If out in sun, try to shade student's head
- Notify parent/guardian

Emergency Plan:

9-1-1 will be called if:

- Seizure lasts longer than 5 minutes
- Student is having difficulty breathing
- Vomitus is aspirated
- A significant injury occurs during the seizure
- Seizure reoccurs
- Other: Parent requests or cannot be located.

What would you like school staff to do (other than routine 1st aid) if your child has a seizure at school?

Call parent when:

Parent signature _____ Date _____

Physician signature _____ Date _____
(not required)

Reviewed by LSN _____ Date _____