EDMOND PUBLIC SCHOOLS

Seizure Medical Management Plan

Name: _____ DOB _____ Grade_____ School Year: _____
Teacher: _____ School: _____

Parent/Guardian: _____
Home: _____ Cell: _____ Work: _____
Emergency contact: _____
Phone: _____
Primary Physician: _____ Phone: _____
Preferred Hospital: _____

SEIZURE INFORMATION

What type of seizure does your child have? _____

How long has your child had seizures? _____

How long does the seizure usually last? _____

How often does your child have seizures? ___day ___week ____month ____ year

What is the usual time of the day seizures occur? _____

Date of last seizure: _____

Medications taken at home: _____
_____

Medications to be administered at school: _____
_____
_____

Check the following signs of seizure activity that are typical for this student:

☐ Changes in senses
☐ Unusual smells or tastes reported
☐ Change in behavior
☐ Cries or shouts out
☐ Visual disturbances, such as staring
☐ Aggressive behavior or rage
☐ Loss of consciousness
☐ Incontinence of urine/feces
☐ Involuntary movement, such as stiffness, tremors, jerking, shaking, loss of muscle control, falling, tongue biting

☐ Other: _____

(over)

Student Name _____ Grade _____

SEIZURE EMERGENCY ACTION PLAN

Actions if a seizure occurs while student is at school:

- Assist student to the floor and remove obstacles from area.
- Call school office. Office will call student's contacts and page school nurse.
- Watch breathing, movements and length of seizure activity
- Remain with the student at all times.
- Do not restrain student. Do not place **anything** in their mouth.
- Do not give them food, drink or oral medications during seizure activity.
- Call 911 if _____

ANY SEIZURE ACTIVITY LASTING LONGER THAN 5 MINUTES CALL 911

ANY TIME A BREATHING PROBLEM IS SUSPECTED -- CALL 911

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I give permission to the school nurse and other staff members of _____ _____ School to perform and carry out the emergency care tasks as outlined by _____'s Seizure Medical Management Plan. I also consent to the release of the information contained in this Seizure Medical Management Plan to all school staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____

Parent/Guardian Signature Date

Acknowledged and received by:

_____

School Nurse Date

Revised 10/2013