SEIZURE
HEALTH MANAGEMENT PLAN

Student:	School:
DOB:	School Year:

PARENTS/GUARDIANS:	
Mother:	Father:
Home Phone:	Home Phone:
Work: (Mom)	(Dad)
Cell: (Mom)	(Dad)
Other Contacts:	
Name:	Phone:
Name:	Phone:

Physician:	Phone:
Physician:	Phone:
Medical Facility (Preference):	

Description/Appearance of Seizures:

Date of last seizure:

Medications:		
Name:	Dose:	Frequency:
Name:	Dose:	Frequency:
Name:	Dose:	Frequency:

Management Plan for School (what to do if student has a seizure at school):

1. Turn student on side & protect from injury.
2. Call for clinic worker or First Responder.
3. Time seizure & note characteristics.
4. Do not place anything in student's mouth.
5. Administer DIASTAT _____mgs rectally if seizure lasts greater than _____ minutes

Call 911 if:

Seizure lasts longer than 5 minutes
There are multiple seizures without recovery between seizure activity
Difficulty breathing occurs
Significant injury occurs

Transportation Plan:

_____ _____

Parent Signature Date Nurse Signature Date

Revised 1-07