SEIZURE ASSESSMENT AND CARE PLAN

Date:_____

Child's Name: _____ Birthdate: _____ Age: _____

Classroom: _____

At what age did your child have their first seizure? _____

What is the date of their last seizure? _____

Describe the type of seizure: _____

Is your child currently on medication(s) for seizures? Yes: _____ No: _____

If yes, please list daily medications taken at home:

Medication Name:	Dosage:	Time given:

If no, has your child ever been on medications for seizures in the past? Yes _____ No _____

If so, please list previous medications:

Medication Name:	Dosage:	Age Given:	Length of time:

List any physical restrictions or limitations your child may have due to seizures:

_____

_____

_____

_____

SEIZURE EMERGENCY PLAN:

Action for Non-Nursing Personnel:

1. Call the school office and tell them that a child is having a seizure. Report your location.
2. Write down the time the seizure activity began. Monitor and record seizure activity and length of time.
3. Protect the child from injury during seizure.
4. Assist the child to the floor and put something soft under their head.
5. Do not put anything in the child's mouth.
6. Stay with the child until medical professionals arrive. If there are other children in the classroom, have someone take them to another location.

Action for Health Office Staff:

1. Administer medication as prescribed by physician.

Name of medication to be left at school: Exp. Date:
Dosage:
Instructions:

2. Asses the child and call paramedics if they are having difficulty breathing or if the seizure lasts more than 5 min.
3. Initiate CPR if indicated.

Other notes from the parent (be specific):

Dr. Name:	**Dr. Phone #:**
Diagnosis:	**Seizure type:**
Dr. Signature:	**Date:**

Physician comments:

Parent Signature:	**Date:**