

Office of Health Services & Wellness Center for Family, School, & Community Partnerships 123 Main Street, Evansville, IN 47708

PH: 812-435-8279 FAX: 812-435-8635

PLAN OF CARE - SEIZURE

Name:		GradeA	ge
Last Name	First MI		
School			
Parent/Guardian Name		Phone (H)	
Address		Phone (WK)	
Parent/Guardian Name		Phone (H)	
ddress		Phone (WK)	
Emergency Phone Contact	#1		
	Name	Relationship	Phone
Emergency Phone Contact	#2Name		Dhans
Dhysician Student Sees for		Relationship	Phone
Physician Student Sees for			Phone
Other Physician			Phone
ALLERGIES: Food, Medication, etc.			riione
DIET: Special diet, please address any die	etary restrictions or special hydratio	on needs	
DAILY SEIZURE MANAGEM	ENT PLAN (Check each that app	olies to the student):	
Ide	ntify the things which star	t a seizure	
• Exercise • Othe	er		
Comments:			

Please address playground activity, sports **SAFETY PRECAUTIONS:** Protective helmet, etc **MEDICATIONS:** Please address side effects staff need to observe for, or that might interfere with learning. Name of Medication Dosage & Frequency Possible Side Effects Name of Medication Dosage & Frequency Possible Side Effects Dosage & Frequency Name of Medication Possible Side Effects **AURA** (Present prior to seizure) ☐ Yes □ No Please describe if present i.e. visual, auditory, olfactory **EMERGENCY PLAN** Emergency action is necessary when the student has symptoms such as and/or Steps to take during a seizure episode: 1. Contact parent if _____ Seek emergency Medical care - call EMS 911 immediately if student has any of the following: Absence of breathing and/or pulse Seizure of 5 minutes or greater duration Two or more consecutive (without a period of consciousness between) seizures which total 5 minutes or greater Continued unusually pale or bluish skin/lips or noisy breathing after the seizure has stopped Comments/special instructions:

Physician Signature Date

ACTIVITY RESTRICTIONS: