

INDIVIDUALIZED HEALTH CARE PLAN SEIZURE

Date: _____
SY: _____
Site: _____
Grade: _____
DOB: _____
Age: _____

Last Name: _____ First Name: _____

Emergency Contact: SEE SCHOOL DATABASE.

- See Student Emergency Card for additional emergency contact.
- Teacher/Advisor/Coach to copy and carry for all off-campus/after-hours activities.
- Students with Special Health Needs are allowed to participate in all field trips and sports unless indicated:
- Consult with School Nurse for student-specific questions. nurse@puhsd.k12.ca.us

HEALTH HISTORY:

CURRENT MEDICATIONS:

All students requiring medications at school must have a completed Medication Administration Form completed by the Medical Provider on file in the office.

TO PROVIDE ASSISTANCE TO A PUPIL EXPERIENCING A SEIZURE

If You See This:

Type of seizure: _____
Triggers which start a seizure: _____
Possible seizure signs: _____
Usual length of seizure: _____
Other: _____

Do This:

- | | |
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| <ul style="list-style-type: none">• Help the student to the floor and place student on his/her side if drooling or vomiting• Start timing seizure• Clear any objects out the way.• Place something soft and flat under the student's head.• Remove other students from the area• Don't put anything in the student's mouth | <ul style="list-style-type: none">• Monitor the student's breathing.• Do not try to stop the seizure, or hold the student• Stay calm.• Keep the area quiet• Stay with the student until the seizure ends, comfort and allow him/her to rest afterwards.• Notify the parents and document what happened in student's file. |
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Call 911 if:

- 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.

ADDITIONAL INFORMATION: