Township of Union Public Schools
EMERGENCY HEALTH CARE PLAN
SEIZURE DISORDER / EPILEPSY

Seizures (also known as epileptic seizures and if recurrent, epilepsy) are thought to result from disturbances In cells of the brain that cause them to give off abnormal, recurrent, uncontrolled electrical discharges.

Student Name:	*School:*	*Grade:*
Contacts:	*Phone:*	

1. **OPEN AND MAINTAIN AIRWAY.**

2. **KEEP CALM! Provide a safe environment.** Lower student safely to the ground, move any furniture that may be in the way. Call the nurse stating...
"I have an emergency, _____ is having a seizure."
The office will wait for the nurse recommendation to call 911.

3. **You cannot stop a seizure once it has started.** DO NOT restrain the student. DO NOT try to revive the student. Let the seizure run its course. Keep the student safe.

4. **Try to prevent the student from striking his/her head or body** against any hard, sharp or hot object, **BUT DO NOT interfere with student's movements**.

5. **Do NOT put anything in student's mouth.** DO NOT force anything between student's teeth!

6. **Place the student on his/her side if possible.** This will prevent aspiration.

7. **Protect the student's head:** Place something soft, such as a rolled-up coat, beneath the student's head.

8. **Observe the seizure.** A seizure report should be filled out to communicate the observations of the seizure to medical personnel.

SPECIAL INSTRUCTIONS:_____
_____
_____

I hereby request and authorize school personnel to implement the above plan if needed. Authorization includes permission for school personnel and Physician/health care provider to contact each other if needed.

Parent Signature: _____ **Date:** _____
Physician Signature: _____ **Date:** _____

Township of Union Public Schools
Physician Order/ Care Plan for Seizures

Student's Name: _____
School: _____ **Grade:**____ **Date of Birth:** _____
Gender: _____ **Teacher Name:** _____ **Room#:** _____

Physician Section:
List measures school personnel are to take when a seizure occurs at school:

_____
_____
_____
_____

Limitations:

_____
_____
_____
_____

Emergency Medical Services should be called when:

_____
_____
_____

Additional Comments: _____
_____

Medications to be given at school:

Name of Medication	Dose	Route	Time	Possible Side Effects

Physician Signature: _____ Date: _____

Physician Printed Name: _____

Telephone: _____ Fax: _____

Parent Signature: _____ Date: _____

Township of Union Public Schools

Student SEIZURE History

Date:_____
Effective Date:
_____

Student Name	DOB/AGE	Today's Date

Parent Names:_____ Phone #:_____home _____work _____cell

Emergency Contact:_____ Phone #:_____home _____work _____cell

Local Doctor's Name:_____ Phone #:_____work _____other

Neurologist's Name:_____ Phone #:_____work _____other

Date of last doctor visit:_____ Reason for visit:_____

Date of next doctor visit:_____ Reason for visit:_____

Age at 1st seizure:_____ Fever related?_____ How often did they occur?_____ How long did they last?_____

Name/Kind of Seizure:_____

Status Epilepticus ever?_____

Current Medications

Name_____ Dose_____ Time taken_____

Name_____ Dose_____ Time taken_____

Typical Seizure Pattern for this student

Warning signs_____

Usually looks like_____

After it's over_____

How often do they occur?_____ Usually lasts how long?_____

Special things that you do for your child during/after a seizure_____

_____

When do you call 911?_____ Date of last 911 call_____

Take your child to ER?_____ Date of last ER visit_____

Other information:_____

_____

_____

Aura or indication before seizure to alert you that seizure is about to occur? ☐Yes ☐ No

If yes, what?_____

Please check (✓) the following boxes to indicated what activity you usually see with your child's seizures:

Body involved:	☐upper	☐lower	☐whole	☐right arm	☐right leg	☐left arm	☐left leg
Extremity involved:	☐straight	☐bent	☐rigid	☐limp	☐jerking	☐trembling	☐twitching
Face involved:	☐right	☐left	☐rigid	***Head turns:***	☐right	☐left	☐down ☐back
Mouth involved:	☐open	☐closed	☐ drooling	☐vomiting	☐grimacing	☐twitching	
Eyes involved:	☐open	☐closed	☐fluttering	☐rolled back			
Breathing involved:	☐slows down	☐stops (how long?_____)		☐labored	☐quiet	☐wet/raspy	☐sounds
Skin color:	☐pale	☐gray	☐blue	☐red/flushed			
Alertness:	☐unconscious		☐ semi-conscious		☐ fully awake		
Communication:	☐cries out	☐talks coherently/responsively		☐can't talk	☐nods head		
Bladder control:	☐wets self	☐bowel control: soils self					
Recovery:	☐drowsy	☐sleeps (how long?_____)		☐confused	☐mostly alert	☐fully alert	

Township of Union Public Schools
Individual Health Care Plan
SEIZURES/EPILEPSY

Date: _____
Effective Date: _____

Student Name	DOB/AGE	Today's Date

Call 911 immediately? ☐ Yes ☐ No
Call 911 only if seizure lasts longer than: ☐ 5 minutes ☐ 4 minutes ☐ 3 minutes ☐ 2 minutes

Contact parent immediately and request they come to the school.

Note time, duration and description of seizure.

WHAT TO DO/NOT DO DURING A SEIZURE:

DO NOT:
- Restrain the student.
- Stimulate by rubbing any part of the student's body.
- Try to force mouth open or put anything into the mouth.
- Move the student during the stiff and shaking part of the seizure.
- Be alarmed by movements and sounds coming from the student.

DO:
- Stay calm, *do not panic*!
- Reassure other students that this is "normal" for this student.
- Gently move the student to the floor when possible.
- Protect the student from injuring him/herself
  - Move desk, books, and other objects away from the student.
- Turn the student on his/her side if on the floor.
  - Make sure the airway is open – may have to tile head backwards slightly.

Parent Names:
_____ **Phone #:**_____home _____work _____cell

Emergency Contacts:
_____ **Phone #:**_____home _____work _____cell

Local Doctor's Name:
_____ **Phone #:**_____work _____other

I have read the above and agree to have the Information shared with the following people:

_____ _____
Parent's Signature Date

_____ _____
Nurse's Signature Date

☐ Principal
☐ Teaching staff
☐ PE teacher
☐ Office Staff
☐ Instructional Assistant
☐ Playground Supervisor
☐ Bus Driver bus#____
☐ Counselor
☐ Psychologist
☐ Nurse
☐ Other_____

TOWNSHIP OF UNION BOARD OF EDUCATION
UNION, NJ 07083

Pupil's Name_____ School_____

Address _____ Teacher_____

Telephone No._____ Grade_____

Description of medication provided by physician_____

Diagnosis:_____

School nurse is instructed to administer _____in

the following manner_____

Medication to be administered from _____ to _____

Consideration for Field Trips:

☐ The above named student may skip the dose of prescribed medication on a field day trip.

☐ The above named student may take the prescribed medication upon returning to school from a field trip.

Date_____ _____

(Physician's Signature & Stamp Required)

The school nurse is requested to administer to _____

(Child's Name)

the medication prescribed by the above-named physician.

Signature of Parent/Guardian_____

The completion of this form is the responsibility of the parent. Upon its completion, it is to be given to the school nurse who will give the medication prescribed. This form will be filed in the office of the school nurse.

MEDICATION MUST BE BROUGHT TO SCHOOL BY PARENT IN THE PRESCRIPTION CONTAINER AND HANDED TO THE NURSE.

For School Nurses Use Only:

Date Received	# of Received	Received From/Print Name	Signature	Given to/Print Name	Signature

MEDICATION RECORD: ADMINISTRATION – PHYSICIAN'S ORDER

School Year: _____ School: _____

Student: _____ DOB: ___/___/___ Teacher: _____ Room: _____

MONTHS	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
September																															
October																															
November																															
December																															
January																															
February																															
March																															
April																															
May																															
June																															

INIT.	NAME	INIT.	NAME
____	_____	____	_____
____	_____	____	_____
____	_____	____	_____