MUNDELEIN HIGH SCHOOL

SEIZURE ASSESSMENT and CARE PLAN

School Year:_____/_____

STUDENT:_____Birthdate:_____Grade:_____

PARENT/GUARDIAN NAME:_____

ADDRESS:_____

HOME PHONE:_____CELL PHONE:_____

PARENT/GUARDIAN NAME:_____

ADDRESS:_____

HOME PHONE:_____CELL PHONE:_____

In the event we are unable to reach you:
EMERGENCY PHONE CONTACT _____
(other than parent) **Name** **Relationship** **Phone**

At what age did your child have his/her first seizure?_____

Date of last seizure?_____

Describe the type of seizure?_____

Describe what the seizures look like. _____

_____

_____

Is your child currently on medication(s) for seizures? Yes_____ No_____
If, yes, Daily Medication Taken at Home:

Name	**Dosage**	**Time**
1.		
2.		
3.		

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

_____

_____

please complete both pages

SEIZURE EMERGENCY PLAN **Name**_____

Please check all that apply for a step by step emergency plan in the event your child has a seizure at school:

Action for Non-Nursing Personnel

_____ Call the classroom emergency button on the phone to radio the nurse. Report name of student and room room number

_____ Note time seizure activity began. Monitor and record seizure activity and length of time.

_____ Protect student from injury during seizure; move furniture away

_____ Assist student to the floor and put something soft under their head.

_____ Do not put anything in the student's mouth.

_____ Stay with student until the nurse or health aide arrives. If there are other students in the classroom, they should wait in the hall.

Action for Health Office Staff

_____ Will administer medication as prescribed by physician.

List medication_____

_____ Will asses student and call paramedics if difficulty breathing or seizure lasts more than 5 minutes.

_____ Will initiate CPR if indicated.

Other Important Information:

_____

_____

_____

_____

When was last physician visit?_____

Child's diagnosis_____

Seizure type_____

Name of physician treating your child for seizures:_____

_____

address phone fax

_____

Physician's signature **Date**

Physician comments:_____

_____

_____

_____

May the school nurse contact the physician in case there are any questions or concerns in making an emergency plan for your child? Yes_____ No_____

_____

Parent/Guardian Signature **Date**

Received/Reviewed by:_____**Date**_____

School nurse