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**

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**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**