Yuma School District One
ONE Community Pursuing Excellence

Seizure Emergency Care Plan

School Year: March 1st, 2024 to September 30th, 2025

School_____ Teacher:_____

Name: **DOB:** **Grade:** **Bus:**

Photo Here

Healthcare Provider to Complete this Section

Significant Medical History:

Seizure Triggers/Warnings:

Seizure Type	Length	Frequency	Description

Emergency Medication Orders to be given during school hours	Dosage & Time of Day to be GIven	Common Side Effects and Special Instructions

Student's usual response after seizure:

Please notate any precautions or any special considerations for staff (sports, field trips, school sponsored events)

Is emergency medication "required" during bus transport (If yes, please notate in the box to the right)	☐ YES	☐ NO	**What specific medication is required during transport?**
Does student have a Vagus Nerve Stimulator?	☐ YES	☐ NO	
Should student rest in school health office after a seizure	☐ YES	☐ NO	
If yes, when should student be able to return to class?			

Seizure First Aid

- Time seizure
- Protect student from injury
- Call Health Office for RN/HA
- Do NOT restrain
- Do NOT put anything in the mouth
- Do no leave student until conscious

For Tonic-Clonic (Grand Mal)

- Protect head & remove glasses
- Keep airway open, check breathing
- Turn student on side

Seizure Emergency Action Plan (check all that apply)	A "SEIZURE EMERGENCY" FOR THIS STUDENT IS DESCRIBED AS WRITTEN BELOW:	CALL 911
☐ Time seizure and make student safe		- First known seizure - Convulsive seizure lasting more than 3 minutes - Seizures are repeating without regaining consciousness - Student has difficulty breathing - Student has diabetes - Student is in water
☐ Call school health office at phone number		
☐ Trained staff will administer medication (if applicable)		
☐ Call 911 (if applicable)		
☐ Notify Parent		
☐ Other		

Treating Physician (Print):_____ Phone:_____

Treating Physician (Sign):_____ Fax:_____

Parent / Guardian to Complete this Section

I agree with this seizure emergency care plan and authorize permission for this medication to be given to my child. **I further authorize the release of all medical information about my child's seizure diagnosis between the school nurse and healthcare provider.** I agree this emergency care plan may be shared by the health office to staff, teachers and the transportation team involved with my child's care.

Parent Signature: _____ Date:_____

Parent Name (print): _____ Phone:_____

Emergency Contact:_____ Phone:_____

School RN and Health Assistant to Review and Sign this Section

RN Signature:_____ Date:_____

Health Assistant Signature:_____ Date:_____

RN has reviewed and trained the health assistant listed above how to care for student with Seizure Emergency Care Plan.

HA to sign form after training session is complete and content is fully understood in the care and treatment of student.