Deer Valley Unified School District No. 97

# Student Seizure Information Sheet

**Date:** ___________________

**Student Name:** __________________________________

**Birthdate:** _____________ **Age:** __________________

**Teacher:** _____________________ **Room Number:** _________

How long has your child had seizures?
_________________________________________

How often do the seizures occur?
_____________________________________________

Has he/she been hospitalized in the past year to treat seizures? _______
If yes, when?
______________________________________________________________

Who is their physician?
______________________________________________________

Physician phone number: _______________________________

Please describe what happens during the seizure activity:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

What triggers the seizures? (example – noise, blinking lights):
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

How long does the seizure activity last?
___________________________________________________________________________
___________________________________________________________________________

**Call 9-1-1 if seizure activity does not stop after ___________ minutes.**

Are there any warnings and or behavior changes before the seizure? If yes, please describe:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Does your child need any protective equipment (helmet) or activity adaptations at school? _________ If yes, what?
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

How long after the seizure should your child wait until they return to regular school activities?
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

What medication(s) is your child taking to treat the seizures?

| Medication | Dosage | Time (s) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

***It is the responsibility of the parent to provide any medication that the child needs at school to treat seizure activity.***

**PLEASE ADVISE SCHOOL NURSE OF ANY MEDICATION CHANGES**

**STUDENT NAME_______________________________ GRADE_________**
**TEACHER__________________________ BUS NUMBER _____________**

## GENERAL TREATMENT PLAN FOR SEIZURE ACTIVITY AT SCHOOL

- **KEEP CALM**
- ***<u>LOOK AT THE CLOCK - SAY THE TIME OUT LOUD</u>***
- Begin timing the seizure
- Help child to the floor to help avoid injury.
- Turn the child the side so saliva can flow from mouth.
- Notify the nurse of seizure activity.
- Stay with the student during the seizure, provide comfort, and speak gently.
- Provide a safe environment by removing hazardous objects.
- **DO NOT RESTRAIN STUDENT. DO NOT PUT ANYTHING IN CHILD'S MOUTH.**
- Protect head from injury. Loosen tight clothing at neck and waist.
- Have another classroom adult remove/direct students from area or room.
- **Call 9-1-1 if any if the following occurs**:

  **Seizure lasts longer than ________ minutes (per care plan)**
  **The child has difficulty breathing**
  **If color does not return to normal afterward**
  **Serious injury**
  **Other (please list)**
  ______________________________________________________________
- Notify parent of seizure activity.
- Provide rest after seizure. Reorient and reassure child.

Parent's additional information to be added to treatment plan:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

I consent to the release of the above information to be shared with teachers, bus drivers and other school personnel as a part of my child's School Care Plan for Seizures. I will notify the school nurse immediately of any changes in condition, medications, phone numbers, address, emergency contacts, doctor/hospital preferences.

Parent/guardian Signature ________________________________ Date ________

School Nurse Signature __________________________________ Date ________

Teacher Signature ______________________________________ Date ________

Teacher aide Signature __________________________________ Date ________

## SCHOOL RECORD OF SEIZURE ACTIVITY

STUDENT: ________________________________________

| DATE | TIME SEIZURE OCCURED | DURATION |
|---|---|---|
| | | |

What was the student doing before the seizure?

______________________________________________________________

______________________________________________________________

What did the student do during the seizure?

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

What was the child's behavior like after the seizure?

______________________________________________________________

______________________________________________________________

______________________________________________________________

Was the child injured during the seizure?

______________________________________________________________

Who was notified?

______________________________________________________________

______________________________________________________________

Disposition:

- ◻ Child remained in class
- ◻ Sent home
- ◻ Taken to hospital by ___________________________
- ◻ Copy of seizure activity record given to parent