Seizure Management Plan

Oak Creek-Franklin Joint School District, Oak Creek, WI

Student Name : _____ Birthdate: _____

School: _____ Sex: ☐ M ☐ F

Emergency Contact #1: _____ Home #: _____ Work #: _____

Emergency Contact #2: _____ Home #: _____ Work #: _____

Health Care Provider: _____ Phone #: _____ Preferred Hospital: _____

Daily Medications: _____ Warning Signs: ☐ Yes ☐ No What? _____

Diastat: ☐ Yes ☐ No Location to be kept: _____ Vagus Nerve Stimulator (VNS) ☐ Yes ☐ No

Versed: ☐ Yes ☐ No Location to be kept: _____

Observations/Symptoms

- ☐ Blank Stare/daydreaming
- ☐ Not oriented to time or place
- ☐ Chewing movements
- ☐ Rapid blinking/eye movements
- ☐ Muscle jerking
- ☐ Loss of muscle tone
- ☐ Sudden Collapse

Action Steps

Assist student to lie down
Gently turn student onto his/her side
Protect student's head from injury (use pillow or clothing)
Do not place anything in student's mouth
Remove nearby objects to prevent injury
Allow rest after seizure. May stay in school
Notify the student's parent
If ordered administer Diastat if seizure longer than _____ minutes
If ordered access VNS as indicated
Document appropriately

Other _____

_____

_____

_____

Call 9-1-1 if:

The student has no history of previous seizure
The seizure occurs in water
The seizure lasts longer than _____ minutes
There is a series of seizures
The student is injured during the seizure
Diastat is administered
Versed is administered

I agree to the above action plan and allow this information to be shared confidentially as determined by the school principal.

_____ _____

Signature (Parent/Guardian) Date

_____ _____

Physician's Signature Date

_____ _____

Physician Address Phone/Fax #

Revision Date: 5/16/2018