Hortonville Area School District

Health Services-Seizure action plan

Insert Photo

Student Name:	Birth Date:
Parent/Guardian:	Work Phone:
Cell Phone:	Home Phone:
Provider:	Phone:
Grade:	Teacher:
Student Name:	Birth Date:

Triggers or Warning signs: _____

SIGNS OF SEIZURES: PLEASE CHECK BEHAVIORS THAT APPLY TO YOUR CHILD

SIMPLE SEIZURES	GENERALIZED SEIZURES	**DANGER SIGNS- CALL 911**	BEHAVIORS EXPECTED AFTER A SEIZURE
☐ Lip smacking ☐ Behavioral outbursts ☐ Staring ☐ Twitching ☐ Other: _____	☐ Sudden cry or squeal ☐ Rigidity/Stiffness/Falling down ☐ Thrashing/Jerking ☐ Loss of bowel/ bladder control ☐ Shallow breathing ☐ Stops breathing ☐ Blue/Pale color to lips ☐ Froth from mouth ☐ Gurgling or grunting noises ☐ Loss of consciousness ☐ Other: _____	☐ Convulsive (tonic-clonic) seizure lasts longer than 5 minutes ☐ Student has repeated seizures without regaining consciousness ☐ Student is injured or has diabetes ☐ Student has a first-time seizure ☐ Student has breathing difficulties	☐ Tiredness ☐ Weakness ☐ Sleeping, difficult to arouse ☐ Somewhat confused ☐ Irregular breathing ☐ Other: _____ **Symptoms can last from a few minutes to a few hours.**

BASIC SEIZURE FIRST AID		**SEIZURE EMERGENCY PROTOCOL**
• Stay calm and track time • Keep Child Safe • Do not restrain • Do not put anything in their mouth • Stay with child until fully conscious	**For tonic-clonic seizure:** • Protect head • Keep airway open/ watch breathing • Turn child on their side	**1.** Call 911 (see above danger signs) **2.** Administer emergency medications as indicated below **3.** Notify parent or emergency contact **4.** Notify District Nurse at 920-_____-_____ **5.** Other: _____

TREATMENT PROTOCOL DURING SCHOOL HOURS (INCLUDE DAILY AND EMERGENCY MEDICATIONS)		
Medication	**Dosage & Time of Day Given/Specifications**	**Common Side Effects & Special Instructions**

Does the Student have a **Vagal Nerve Stimulator?** ☐ Yes ☐ No

Special consideration: _____

Physician Signature: _____ **Date:__/__/__**

Medication consent:I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the practitioner as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I further agree to hold the Hortonville Area School District, and the HASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any change in the above orders is necessary. If self-medication is allowed I ask that my child be permitted to self-medicate as authorized by my physician and myself. I understand, as the parent, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events.

Parent/Guardian Signature: _____ **Date:__/__/__**

Copies of health plans are provided to teachers, school staff, lunch/recess aides, and bus driver(s)