HORTONVILLE AREA SCHOOL DISTRICT

HEALTH SERVICES-SEIZURE ACTION PLAN

Child's full name: _____ Date of Birth: _____

Parent/Guardian's Name: _____ Phone number: _____ Secondary number: _____

Parent/Guardian's Name: _____ Phone number: _____ Secondary number: _____

Treating Physician: _____ Phone number: _____ Fax number: _____

Significant Medical History/ Seizure Diagnosis: _____

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 ☐ Falling down ☐ Rigidity/Stiffness ☐ Thrashing/ Jerking ☐ Loss of bowel/ bladder ☐ control Shallow breathing ☐ Stops breathing ☐ Blue 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 • Record seizure in log (form attached) **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)			
Emerg. Med √	**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 agree to give my permission for school personnel to administer this medication to my child according to the directions stated above and to contact my child's practitioner if necessary. 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 in writing at the termination of this request or when any change in the above orders is necessary

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