INDIVIDUAL PLAN OF CARE
Seizure Disorder

Name_____Age_____DOB_____School_____

Mother's Name_____(h):_____(w):_____(m):_____

Father's Name_____(h):_____(w):_____(m):_____

Physician's Name_____office phone:_____

_____office phone:_____

Medications:

_____

_____

_____

If a seizure should occur:

1. Stay Calm!
2. Have student lie on the floor.
3. Remove objects that are near to prevent injury.
4. Cushion student's head with something soft.
5. Remove all students from the immediate scene.
6. Note any movements – i.e. jerking, tremors, eyes rolling back, etc.
7. Note the length of the seizure.
   If the seizure lasts more than _____minutes:

   - ☐ Administer _____
     (medication)
   - ☐ Call 911 – take to the closest hospital.
   - ☐ If second seizure occurs immediately after the first, call 911
   - ☐ Other:_____
8. Call parent.
9. Assist student to the Health Room to lie down.
10. Encourage student to go home after the seizure.
11. Refer for counseling as needed.
12. Other_____

_____

_____ _____
(Parent's signature/date) (Student's signature/date)

_____ _____
(Physician's signature/date) (Nurse's signature/date)