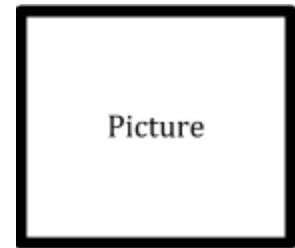




Neenah Joint School District
410 S Commercial St.
Neenah, WI 54956



Seizure Management and Emergency Plan

Student _____ Date _____ Grade _____

Date of Birth _____ School _____ Teacher _____

Address _____ Parent/Guardian _____

City _____ Zip Code _____ Home Phone _____

Emergency Contacts:

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

Name _____ Number _____ Relationship _____

Will your child take seizure medication at school? YES NO

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Behavior of child after a seizure:

Basic First Aid: Care and Comfort

Please describe basic first aid procedures:

<p>Basic Seizure First Aid</p> <ul style="list-style-type: none"> • Stay calm and track time • Keep child safe • Do not refrain • Do not put anything in mouth • Stay with child until fully conscious • Record seizure in log <p>For tonic-clonic seizure:</p> <ul style="list-style-type: none"> • Protect head • Keep airway open/watch breathing • Turn child on side 	<p><u>A seizure is generally considered an emergency when:</u></p> <ul style="list-style-type: none"> • Student has repeated seizures without regaining consciousness • Convulsive (tonic-clonic) seizures • Lasts longer than 5 minutes • Student is injured or has diabetes • Student has a first time seizure • Student has breathing difficulties • Student has a seizure in water
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Emergency Response

(check all that apply)

- Call 911
- Administer Emergency Medications as listed in plan
- Notify Parent
- Other _____

Treatment Protocol During School Hours (Include Emergency Medications)

√ if an Emergency Med	Medication	Dose	Time	Special Instructions	Expiration date

*All prescription medications must be in a properly labeled pharmacy box/bottle.

Does student have a Vagus Nerve Stimulator (VNS)? Yes No

If yes, please explain use of magnet. _____

Please list any other accommodations, considerations, or precautions that need to be made.

Parent consent for management of health condition while at school or other school related activities

I, the parent/guardian of the above named student, request that this action plan be used to guide the care of my child in case of a health care emergency. I agree to:

- Provide the necessary supplies and equipment.
- Notify the school staff or school district nurse of any changes in the student's health status.
- Notify the school staff and complete new consent for changes in orders from the student's health care provider.
- Authorize the school nurse to communicate with my child's primary care physician or specialist regarding my child's health condition as needed.
- School staff interacting directly with my child may be informed about this health care plan.
- Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists.

Parent/Guardian Signature _____ Date _____

Physician Information

Print Name of Provider _____ Clinic Name _____

Phone Number _____ Fax Number _____

Address _____

Signature of Provider _____ Date _____