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

Picture

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:_____

Basic Seizure First Aid

- Stay calm and track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A seizure is generally considered an emergency when:

- 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

Emergency Response

(check all that apply)

☐ Call 911
☐ Administer Emergency Medications as listed in plan
☐ Notify Parent
Other_____

-over-

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_____

Revised 5/2019