# Education at its best.

MONTELLO SCHOOL DISTRICT

**Seizure Emergency Plan**

STUDENT:___________________________Teacher:____________________School:_______________________Age:_____

Grade:____________________Address:________________________________________Birthday:________________________

## Seizure Description

Seizure type:_____________________________________________________________________________________

Description of seizure: ______________________________________________________________________________

Possible triggers: ____________________________________________________________________________________

Frequency of seizures: ____________ per __________________. Last date of seizure was: __________________________

Average length of seizure activity: __________________. Usual time of day of seizure activity:________________________

Average time until student can return to regular activities: ______________________________________________________

Student's reaction to seizure:_________________________________________________________________________

| **Name of Daily Medication** | Dose | Route | Time of Day | Start Date | Stop Date |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |

| **Name of EMERGENCY Medication** | Dose | Route | When to be Given |
|---|---|---|---|
| | | | |

**First Aid**

- Keep CALM and reassure other people who may be nearby.
- Don't hold the person down or try to stop their movements.
- Time the length of the seizure with your watch.
- Call for "Medical Team" (if in school) or 911 (if out of school)
- Clear the area around the person of anything hard or sharp.
- Loosen ties or anything around the neck that may make breathing difficult.
- Put something flat and soft, like a folded jacket, under the head.
- Turn gently onto one side. This will help keep the airway clear.
- Do not try to force the mouth open with any hard implement or with fingers.
- Don't attempt artificial respiration EXCEPT in the event that a person does not start breathing again after the seizure has stopped.
- STAY WITH THE STUDENT.

*(see next page)*

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MONTELLO SCHOOL DISTRICT

District Phone: 608-297-7617 Fax: 608-297-7726

This **Seizure Medical Management - Emergency Plan has been approved by:**

**PHYSICIAN ORDER:** The above medication/procedure is to be administered/performed during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure and understand medication will be given by non-medically trained school personnel.

Please contact me if the following symptoms occur:_______________________________________________

Physician Name: ______________________ Clinic:______________________Fax #:______________

Address:_____________________________________________Phone #:__________________

Physician Signature: ________________________________ Date: ________________________

I hereby agree to give my permission to the school nurse/principal to contact the child's practitioner in regard to this plan and/or medication. I further agree to hold the School District of Montello and the identified person(s) harmless in any or all claims arising from the administration of any medications given at school. I agree to notify the school in writing when any changes in the Medication Consent Form are necessary. I also consent to the release of the information contained in this Seizure Medical Management - Emergency Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

| ______________________________ | ____________________ | ________________ |
|---|---|---|
| **Student's Parent/Guardian Signature** | **Phone Number** | **Date** |