

# Seizures

# Luverne Public Schools

Health Care/Emergency Plan  
**Health Services**  
Phone: 507-283-4497/4491  
Fax: 507-283-9681

### STUDENT INFORMATION:

STUDENT: \_\_\_\_\_ SCHOOL: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ GRADE: \_\_\_\_\_

### CONTACTS:

Parent/Guardian: \_\_\_\_\_ Home phone: \_\_\_\_\_  
Work: \_\_\_\_\_ Cell/Pager: \_\_\_\_\_  
Physician/Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### MEDICATIONS

		Home	School
Name _____	Dose _____	Time _____	_____
Name _____	Dose _____	Time _____	_____
Name _____	Dose _____	Time _____	_____
Name _____	Dose _____	Time _____	_____

**ALLERGIES:** \_\_\_\_\_

### SEIZURE INFORMATION:

1. Last observed seizure (Month and Year): \_\_\_\_\_
2. Number of seizures in the year: \_\_\_\_\_
3. Warning signs: \_\_\_\_\_
4. Length of typical seizure: \_\_\_\_\_
5. Parts of body involved (please describe): \_\_\_\_\_

### TYPES OF LIMITATIONS:

Play ground equipment:	_____ yes	_____ no	_____ N/A
Swimming	_____ yes	_____ no	_____ N/A
Machinery operation	_____ yes	_____ no	_____ N/A
Other:			

**FIELD TRIP PLAN:** \_\_\_\_\_

**EMERGENCY PLAN OF CARE:**

- 1. Call 911 and parent if:
  - seizure is longer than \_\_\_\_minutes
  - student has one seizure after another
  - student is having difficulty breathing

**FIRST AID FOR SEIZURES:**

- 1. Call the School Nurse (extension 3080 in the morning and 2080 in the afternoon)
- 2. Gently protect the student from injury. Help him/her to lying position, preferably on side, place something soft under head, loosen tight clothing and clear the area of hard or sharp objects.
- 3. Stay with the student until full recovery has occurred. Allow the student to rest if he/she needs it.
- 4. Be reassuring and supportive when consciousness returns.
- 5. Document the following:
  - What happened before, during and after the seizure?
  - Time seizure began and the length of the seizure.
  - What parts of the body were involved and how.

**DO NOT:      FORCE ANY OBJECTS INTO THE PERSON’S MOUTH**  
**RESTRAIN MOVEMENTS**  
**OFFER FOOD OR LIQUIDS UNTIL FULLY AWAKE**

Nursing Diagnosis:

- 1. Potential for physical injury.
- 2. Potential for disturbance in self-concept and or social isolation.

Goal:

- 1. Prevent physical injury during a seizure.
- 2. Acceptance of self to be a whole person and age appropriate social interaction.

**I give the Licensed School Nurse permission to consult (both verbally and in writing) with the above named student’s physician regarding any questions that arise about the medical condition and /or medications/treatments/procedures being used to treat the condition.    \_\_\_\_yes    \_\_\_\_no**

Parent signature: \_\_\_\_\_ Date:

School Nurse: \_\_\_\_\_ Date:

Physician signature: \_\_\_\_\_ Date:

*Physician signature required only if this form is used as a doctor’s order for medication(s) or treatment(s)*

- \* The school district intends to use the requested information to provide for your child’s health and safety needs while at school.
- \* You may refuse to supply the requested personal information.
- \* If this form is not completed it may result in an incomplete health and safety plan for your child.
- \* Medications are not administered at school without physician and parent signatures.
- \* The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child’s safety and school success.