Wrightstown Community School District

Student Health Services
District Nurse Olivia Koehn RN, BSN|(920) 532-0525 ext. 5016
Health Aide WES Erica Pivonka |(920) 532-4818 ext. 2010| Health Aide WMS Ashley La Roque|(920) 532-5553 ext. 4108
Elementary School Fax (920) 532-4664 |Middle School Fax (920) 532-3869 | High School Fax (920) 532-0860

Seizure Management Plan for School Year: _____

Student Name _____ Date of Birth _____

School Building _____ Teacher _____Grade _____

Parent/Guardian Name and Phone Number(s)_____

Parent/Guardian Name and Phone Number(s) _____

Emergency Contact Name and Phone Number(s) _____

Will your child take seizure medication at school? ☐ **YES** ☐ **NO**
If a prescription seizure medication will be taken daily, a medication consent form will need to be filled out and kept on file at school in addition to this form. If only emergency medication will be taken for seizures at school, this form has a box for that information and no additional form is necessary.

What triggers your child's seizures?

_____

List warning signs of a seizure your child typically exhibits:

_____

Describe the behavior of your child after a seizure:

_____

Does student have a Vagus Nerve Stimulator (VNS)? ☐ YES ☐ NO
If yes, please explain the use of magnet. _____

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

_____

Seizure Information

Seizure Type	Length of time	Frequency	Description

-Turn Over-

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 Convulsive seizures:

- Protect head
- Loosen restrictive clothing
- 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 seizure 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

Basic First Aid: Care and Comfort

Please describe additional basic first aid procedures: _____

_____

_____

EMERGENCY Response

1. Call 911
2. Administer Emergency Medications as listed in plan
3. Notify Parent
4. Other _____

Treatment Protocol for EMERGENCY Seizure Medications:

Medication Name	Dose (amount)	Frequency /Timing	Route	Special instructions/ Negative side effects

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

I, the parent/guardian of the above-named student, grant permission for designated school staff to follow this action plan and request that this action plan be used to guide the care of my child in case of a health care emergency. Furthermore, I agree to:

1. Provide the necessary supplies and equipment, including medication in the original. pharmacy labelled container.
2. Authorize the administration of medication and treatment of health condition per this plan.
3. Notify the school staff or school district nurse of any changes in the student's health status.
4. Notify the school staff and complete new forms as necessary for changes in orders from the student's health care provider.
5. Ensure this form is signed by the appropriate medical provider (provider who manages the medical condition).
6. Authorize the school nurse to communicate directly with my child's primary care provider or specialist regarding my child's health condition.
7. School staff interacting directly with my child may be informed about this health care plan.
8. Submit new forms annually if the health condition still exists or inform the school that the condition no longer exists and provide documentation of such if deemed necessary.
9. Hold without liability the Wrightstown Community School District, its Board of Education, administration, and all employees and agents who are acting within the scope of their duties in all claims arising from the administration of this medication and treatment of this health condition, to policy at school.

Parent/Guardian Signature_____ Date_____

Student Signature (if the student is 18 years old or will turn 18 during the pertaining school year)

_____ Date_____

Physician Information

Print Name of Provider_____ Institution Name _____

Phone Number_____ Fax Number _____

Address _____

Signature of Provider_____ Date_____

School RN Signature _____ Date_____