School Year

20___-20___

Jackson-Madison County School System
Seizure Disorders

Child's Information: **School:** _____

Name of Child:_____ Date of Birth: _____

Grade/Child's Age:_____ Homeroom Teacher or Instructor: _____

Emergency Information:

Parent(s') or Guardian(s') Names: _____

Mother's or Guardian(s') Telephone (W): _____ Father's Telephone (W): _____

Mother's or Guardian(s') Cell/Pager: _____ Father's Cell/Pager: _____

Mother's or Guardian(s') Telephone (H):_____ Father's Telephone (H): _____

Child's Healthcare Provider: _____ Healthcare Provider Telephone:_____

Child's Neurologist: _____ Specialist's Telephone:_____

Please provide names and contact information in the event a parent/guardian cannot be reached:

1:_____ Relation:_____ Telephone: _____

2:_____ Relation:_____ Telephone: _____

Preferred Local Emergency Department: _____

Preferred Comprehensive Regional Pediatric Center:

[ ] Jackson-Madison Co. General Hospital [ ] Le Bonheur– Memphis [ ] Tennova– Regional [ ] Vanderbilt– Nashville

My child has the following other illnesses/disabilities: _____

_____

Triggers that may bring on seizure: _____

_____

_____

_____

Signs and symptom(s): [Please check the symptom(s) that occur in your child.]

[ ] Aura (symptoms before seizure:_____)
[ ] Generalized convulsions involving entire body
[ ] Pallor or skin discoloration
[ ] Labored (noisy) breathing
[ ] Other: _____
Is your child aware of impending seizure activity: [ ] Yes [ ] No

[ ] Loss of consciousness: may fall to ground
[ ] Involuntary loss of urine or feces
[ ] Staring/blank gaze/day dreaming
[ ] Dilation of pupils

My child has the following other chronic illnesses/disabilities: _____

_____

_____

Allergies: _____

_____

_____

Child's Limitations or Special Considerations: _____

_____

_____

ALL CURRENT MEDICATIONS

Name of Medication	Dosage and Strength	Purpose	Day Schedule	Time of Day

I understand that it is my responsibility to keep this information current.
Please notify School Nurse and provide an updated/current form on at least an annual basis.

Parent's/ Guardian's Signature:_____ Date:_____

Child's Name_____

Jackson-Madison County School System
Seizure Disorders– EMERGENCY PLAN FOR A SEIZURE

Give emergency medications as listed below:

DURING THE SEIZURE ACTIVITY

1. **STAY WITH THE CHILD**
2. A. If falling or generalized jerking occurs, place child on floor.
   B. Gently support head to side positions and monitor breathing and pulse.
   C. **DO NOT** restrain child. **DO NOT** try and place anything in the child's mouth or between child's teeth.
   D. Protect child by moving items away that may cause injury– e.g. desk, chairs.
   E. Loosen clothing at neck and waist; remove eyeglasses (if applicable).
3. Have another classroom adult remove/direct students from the area.
4. Use watch. **TIME THE SEIZURE.** Observe pattern of the seizure and be prepared to describe it.
5. **CALL 9-1-1 if child exhibits:**
   A. Absence of breathing and or pulse (start cpr for absence of breathing and pulse)
   B. Seizure of 5 minutes or greater duration.
   C. Two or more consecutive (without a period of consciousness between) seizures ≥5 minutes.
   D. No previous history of seizure activity
   E. Continued unusually pale or bluish skin/lips or noisy breathing after the seizure has stopped.

Preferred Local Emergency Department: _____

Preferred Comprehensive Regional Pediatric Center:

[ ] Jackson– Madison Co. General Hospital [ ] Le Bonheur– Memphis [ ] Tennova– Regional [ ] Vanderbilt– Nashville

AFTER THE SEIZURE ACTIVITY

1. Reorient and reassure child
   A. Allow/assist chance into clean clothing if necessary.
   B. Allow child to sleep, as desired, after seizure.
   C. Allow child to eat, as desired, once fully alert and oriented.

2. A child recovering from a generalized seizure may manifest abnormal behavior such as incoherent speech, extreme restlessness, and confusion. This may last from five minutes to hours.

3. Inform parent immediately of seizure by telephone if:
   A. Seizure is different from usual type/frequency/has not occurred at school in past month.
   B. Seizure meets criteria for 9-1-1 emergency call.
   C. Child has not retuned to "normal self" after 30/60 minutes.

IT IS THE PARENT'S RESPONSIBILITY TO DETERMINE FOLLOW-UP STEPS.

Individual Considerations: _____
_____
_____

This child also has the following chronic illnesses/disabilities:_____
_____
_____

Medical Provider's Name: _____ Phone number:_____
Medical Provider's Signature: _____ Date: _____
School Nurse: _____ Contact Number: _____