

Seizure Management and Treatment Plan Form

In accordance with SB 1506, this form is designed to help create a plan for managing student seizures. It consists of several questions about seizure history, medications, precautions, and other considerations. Please fill out the form and provide it to the campus nurse or other appropriately identified personnel.

If filling out the form by hand, write on the back or add additional pages as needed for more space.

Student name: _____ Date of birth: _____ Date: _____

Name of parent or guardian: _____ Phone: _____

Email: _____

Name of treating physician: _____ Phone: _____

Email: _____

Emergency contact: _____ Relationship: _____

Phone: _____ Email: _____

1. Describe the medical history significant to the student's disorder (i.e., genetic, illness, injury, unknown):

2. Describe each type, length, and frequency of seizure the student has experienced:

3. Describe each type of seizure the student has experienced:

4. What are the student's seizure triggers or warning signs?

5. Describe the student's ability to manage seizures and their level of understanding of the seizures:

6. What is the student's response after a seizure?

7. What is the basic first aid and care provided to the student during a seizure?

8. Does the student need to leave the classroom after the seizure? Yes No If yes, please explain:

9. What is the process of the student's return to the classroom following a seizure (if applicable)?

10. Describe what constitutes a seizure emergency for the student:

11. Describe emergency protocol for district personnel to follow in the event of a student seizure:

Student Name: _____

12. Describe the student's medication guidelines and other protocols and procedures to be administered by the district personnel during school hours:

13. List each daily medication taken for seizure management including its name, dosage, and time the medication is given. Also, list common medication side effects and any special instructions.

Medication Name	Dosage	Time to be Given	Common Side Effects	Special Instructions

14. Does the student have a vagus nerve stimulator? Yes No

If yes, what is the treatment protocol for appropriate magnet use?

15. Does the student have any special considerations or precautions applicable in relation to their seizure disorder?

16. Transportation Plan – Same as campus emergency plan? Yes No If no, explain below:

Signature of Student's Parent/Guardian

Print Name

Date

Signature of Treating Physician

Print Name

Date