PHARR-SAN JUAN-ALAMO INDEPENDENT SCHOOL DISTRICT

Seizure Care Plan for School Year _____

- - - Plan must be renewed each school year - - -

Student's Name: _____ Student ID: _____

Date of birth: _____ Grade: _____ Teacher: _____

TO BE COMPLETED BY PHYSICIAN

Seizure type: _____ Date of diagnosis: _____

Dietary therapy: ☐ No ☐ Yes _____

- - - Special Diet form **must** be completed if a special diet is to be provided at school - - -

Vagus nerve stimulator: ☐ No ☐ Yes Location: _____ Date inserted: _____

MEDICATIONS (home AND school)	Name of Medicine	Dose	Frequency/Time	Give at School
ROUTINE Medication(s)				
EMERGENCY Medication				

RED ZONE – *Emergency!*

☐ Give ***EMERGENCY*** medication if

- One seizure lasts more than _____ minutes
- More than _____ seizures in _____ hours
- _____

☐ Use VNS magnet _____

☐ Call 9-1-1 if

- Seizure does not stop by itself or with VNS within _____ minutes
- Seizure does not stop within _____ minutes after giving ***EMERGENCY*** medication
- Breathing, heart rate or behavior does not return to normal after seizure is over
- Injury occurs or is suspected during seizure
- Notify parent/guardian and school administrator after calling 9-1-1

☐ Once seizure is over and behavior is back to normal, student may return to class/resume usual activities

Physician's Name (print): _____ Phone: _____

Physician's Signature: _____ Date: _____

Address: _____ City/Zip: _____