

**St. Matthew School  
Individual Health Care Plan: Seizure**

Student's Name \_\_\_\_\_ Grade/teacher \_\_\_\_\_  
Diagnosis/Student condition \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Parent contact \_\_\_\_\_  
Treating Physician \_\_\_\_\_  
Significant Medical History \_\_\_\_\_  
Seizure triggers or warning signs \_\_\_\_\_  
Medication taken by student \_\_\_\_\_

**Seizure Protocol**

- **Stay calm and track time**
- **Keep child safe and move any hazards (have other children leave area)**
- **Do not restrain child or move child**
- **Do not put anything in mouth**
- **Protect head, assess airway/watch breathing**
- **Notify parent or emergency contact**
- **Yes or No Call 911 for transport to \_\_\_\_\_**
- **Administer emergency Medication \_\_\_\_\_**
- **Actions to be taken during seizure \_\_\_\_\_**

**Seizure Information:**

**Time seizure started** \_\_\_\_\_  
**Time seizure ended** \_\_\_\_\_  
Location of student \_\_\_\_\_  
Describe seizure \_\_\_\_\_  
Describe student's activities prior to seizure \_\_\_\_\_  
Did the student have more than one seizure without regaining conscious? \_\_\_\_\_  
Did the student have a second seizure after regaining conscious? \_\_\_\_\_  
Describe student's response after seizure:  
Alert awake sleeping confused responsive unconscious  
Other \_\_\_\_\_  
Describe student's muscle tone after the seizure \_\_\_\_\_

School nurse will provide the following information to indicated school staff

---

I give permission for my child to be given the above care  
Parent signature \_\_\_\_\_ Date \_\_\_\_\_

MD signature \_\_\_\_\_  
School nurse signature \_\_\_\_\_ Date \_\_\_\_\_