

**CHARLES A. BEARD SCHOOL CORPORATION**  
**SEIZURE PLAN OF CARE**

Name: \_\_\_\_\_ Grade/Teacher \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ Cell: \_\_\_\_\_ **BUS #** \_\_\_\_\_

***TYPE OF SEIZURE:*** \_\_\_\_\_

**EMERGENCY CONTACT #1:** \_\_\_\_\_  
(Other than above) Name Relationship Phone

**EMERGENCY CONTACT #2:** \_\_\_\_\_  
(Other than above) Name Relationship Phone

**Physician student sees for seizures:** \_\_\_\_\_  
Name Phone

***CURRENT MEDICATIONS: (include dosage)***  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**EMERGENCY PLAN**

Emergency action is necessary when the student has symptoms such as:

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**STEPS TO TAKE DURING AN EPISODE:**

1. Stay calm.
2. Stay with the student at **ALL** times.
3. Notify the nurse **IMMEDIATELY**.
4. Note the time the seizure begins.
5. Do not restrain the student (a seizure can't be stopped once started without medication. Most will be self limiting).
6. If the student is standing or in a chair assist them to the floor.
7. Clear the area of any hard, sharp, or dangerous objects.
8. Do not force anything into the mouth. The tongue will **NOT** be swallowed.
9. If possible, turn student onto his/her side, with mouth down.
10. Loosen clothing from around the neck of the student.
11. Monitor breathing and pulse. Breathing may become very shallow. CPR is rarely needed.

**BY SIGNING THIS FORM, I AGREE TO ALLOW THIS INFORMATION TO BE SHARED WITH ANY AND ALL EMPLOYEE PERSONNEL WHO MAY BE IN CONTACT WITH MY CHILD.      UPDATED 4/17**

**PARENT/GUARDIAN'S SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_