Rockford Public Schools
School-Based Seizure/Epilepsy Care Plan

Student Name:	Date:
School:	Date of Birth:
Parent's Name:	Phone:
Physician's Name:	Hospital:
Allergies to Medications:	Teacher/Homeroom:
Types of Seizure: ☐ Grand Mal/ Tonic Clonic • Entire body stiffens/jerking movement	☐ Absence Seizure/Partial Complex • Staring spell, blinking eyes

Medication to be taken at school:	Dosage:

Action Plan for Seizures

1. Protect student from injury.
   - Lower student to floor
   - Place on side and try to keep the airway open
   - Place soft item under head
   - Do Not put anything in the student's mouth
   - Do Not interfere with student's movements
   - Let the seizure run its course
2. Remove other students from the area.
3. Call Parents.
4. Call school nurse: Ext. 7030 Cell: 690-7100
5. Observe and document details of seizure
   - Behavior before and after seizure
   - Length and characteristics of seizure

Emergency Treatment
Dial 911

- **If seizure lasts greater than 2 minutes**
- **If seizure is related to a head injury**
- **For first time seizures**
- **If student is having difficulty breathing**
- **Other: ______________________________**

Special Instructions:

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As parent/guardian of the above named student, I give permission for use of this health plan in my student's school and for the school nurse to contact the above providers regarding the above condition. Orders are valid through the end of the current school year.

Parent Signature: ______________________________ Date:

Nurse Signature: ______________________________ Date:

☐ Parent signed plan

LR/2010