Jonesville Community Schools
School Plan for a Student with a Seizure Disorder

Student_____ Grade_____ Teacher_____

Date of Birth_____ Age at Time of Diagnosis_____

Parent(s)/Guardian_____

Home Phone_____ Work Phone_____ Cell Phone_____

Other Emergency Contact_____ Phone_____

Health Care Provider_____ Phone_____

Please check the type(s) of seizures this student has had:

- ❑ Absence (Petit Mal) – staring, eye blinking, loss of awareness, other_____
- ❑ Simple Partial (Jacksonian/Focal Motor) – remains conscious, distorted sense of smell, hearing, sight, involuntary rhythmic jerking/twitching on one side, other_____
- ❑ Complex Partial (Psychomotor/Temporal Lobe) – confused, not fully responsive/unresponsive, may appear fearful, purposeless, repetitive movments, other_____
- ❑ Generalized tonic-clonic (Grand Mal) – convulsions, stiffening, breathing may be shallow, lips or skin may have bluish color, unconsciousness, confusion, weariness, or belligerence when seizure ends, other_____
- ❑ Other (please describe)_____

When was this student's last seizure?_____

How often does this student typically experience seizures? ❑Daily ❑Weekly ❑Monthly ❑Other_____

_____

How long does a typical seizure last? _____seconds _____minutes _____other

Has this student ever been treated for status epilepticus (a prolonged seizure)? ❑Yes ❑No

Does this student usually experience any early warning signs/symptoms before a seizure (i.e. sensory or mental auras)? ❑Yes ❑No Please describe_____
Does he/she recognize these signs/symptoms? ❑Yes ❑No

Please check this student's usual signs/symptoms of a seizure:

❑loss of consciousness	❑blank stare	❑falling down
❑twitching/jerking of body part	❑muscle stiffness	❑repetitive acts/movements
❑rhythmic convulsions	❑confusion	❑purposeless activity
❑loss of awareness (i.e. unresponsive)	❑aimless wandering	❑fluttering eyelids
❑loss of control (i.e. bladder, bowel, drooling, etc.)		❑other_____

Please describe how this student acts after a seizure (i.e. drowsy, sleepy, headache, etc.)_____

_____

Please check any known triggers for this student's seizures

❑bright lights ❑stress ❑fever
❑temperature changes ❑loud noises ❑fatigue
❑hunger ❑other (please list)_____

Please list any activities that this student should avoid_____

Please list any specific activities in which this student needs particularly close supervision_____

Medication(s) taken on a regular basis

Name	Route	Dose	Time of Day

Emergency Medication(s): To be given at school by Licensed School Nurse only

Name	Route	Dose	Time of Day

Please list any side effects of this student's medication(s) that may affect his/her learning and/or behavior_____

Please add anything else that you would like school personnel to know about this student's seizures (or related health conditions)_____

Interventions: Please check <u>all</u> that apply:

- ❑ Protect student from injury during seizure. Place on side with something soft under head.
- ❑ Do not attempt to restrain student or use force. Do not place anything in student's mouth.
- ❑ Administer PRN seizure medication(s) if ordered.
- ❑ Monitor and record seizure activity and length.
- ❑ Call 911 if student is in respiratory distress or seizure lasts _____minutes or longer.
- ❑ Notify parent/guardian/other emergency contact/health care provider immediately if student has a fever associated with seizure.
- ❑ Other_____
- ❑ Administer prescribed medication(s)

Name	Route	Dose	Frequency

The school nurse or a representative from Jonesville Community Schools has my permission to contact my child's physician and/or physician's office regarding my child's seizure disorder.

Parent/Guardian Signature_____ Date_____

Physician's Signature_____ Date_____