

**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 movements, 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:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> loss of consciousness                                 | <input type="checkbox"/> blank stare       | <input type="checkbox"/> falling down              |
| <input type="checkbox"/> twitching/jerking of body part                        | <input type="checkbox"/> muscle stiffness  | <input type="checkbox"/> repetitive acts/movements |
| <input type="checkbox"/> rhythmic convulsions                                  | <input type="checkbox"/> confusion         | <input type="checkbox"/> purposeless activity      |
| <input type="checkbox"/> loss of awareness (i.e. unresponsive)                 | <input type="checkbox"/> aimless wandering | <input type="checkbox"/> fluttering eyelids        |
| <input type="checkbox"/> loss of control (i.e. bladder, bowel, drooling, etc.) | <input type="checkbox"/> 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 all 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

Information was provided by \_\_\_\_\_  
Name Relationship Date

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\_\_\_\_\_