



To Be Completed by the Health Care Provider

SEIZURE EMERGENCY CARE PLAN

San Francisco Unified School District Student Support Services 1515 Quintara Street San Francisco, CA 94116-1273 Tel: 415.242.2615 | Fax: 415.242.2618

Name: _____ Grade: _____ Age: _____ Date of Birth: _____
School: _____ Homeroom Teacher: _____ Room: _____
Parent/Caregiver Name: _____ Phone (home): _____ (cell) _____
Address: _____ Phone (work): _____
Health Care Provider Treating Student for Seizure: _____ Ph: _____

To provide assistance to a pupil experiencing a seizure:

If You See This
Type of Seizure _____
Triggers which start a seizure _____
Possible seizure signs _____
Usual length of seizure: _____
Other: _____

Do This

- Help the student to the floor, and place student on his or her side, if drooling or vomiting.
Clear any objects out of the way.
Place something soft and flat under the student's head.
Loosen any tight clothing.
Don't put anything in the student's mouth.
Monitor the student's breathing.
Do not try to stop the seizure, or hold the child down.
Stay calm.
Look at the clock and see how long the seizure lasts.
Stay with the student until the seizure ends, comfort and allow him or her to rest afterwards.
If the child had a febrile seizure, be sure to begin to cool the child with cool cloths.
Reorient the child.
Notify parents, and document what happened in child's file.
OTHER: _____

CALL 911 if...

- Absence of breathing and/or pulse
Seizure of 5 minutes or greater duration
Two or more consecutive (without a period of consciousness between) seizures which total 5 minutes or greater
Continued unusually pale or bluish skin/lips or noisy breathing AFTER the seizure has stopped

I authorize school personnel to implement this Seizure Emergency Plan as described above.

Health Care Provider Signature Date

I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent for school authorities to communicate with the authorized health care provider when necessary. [] My child does not need services

Parent/Caregiver Signature Date