STUDENT PHOTO

SEIZURE EMERGENCY CARE PLAN

For School Use Only
Location of Medication: _____

San Francisco Unified School Distirct
Student, Family, and Community Support Department
School Health Programs
1515 Quintara Street
San Francisco, CA 94116-1273
Tel: 415.242.2615 | Fax: 415.242.2618

TO BE COMPLETED BY PARENT/CAREGIVER

Name: _____ Date of Birth: _____ School: _____

Grade:_____ Homeroom Teacher: _____ Room: _____

Parent/Caregiver Name: _____ Phone (home): _____ (cell):_____

Address: _____ Phone (work): _____ Email:_____

----------TO BE COMPLETED BY THE HEALTH CARE PROVIDER----------

Health Care Provider Treating Student for Seizures:_____ Ph: _____

Type of seizure:_____

Student's most common signs of seizure:_____

ACTIONS TO TAKE

<u>During the seizure</u>

- **Stay calm and stay with the student.**
- **Note length of time of seizure.**
- **Clear any objects out of the way.**
- **Help the student to the floor and place student on his/her side.**
- **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 student down.**

<u>After the seizure</u>

- **Comfort and allow the student to rest afterwards.**
- **Re-orient the student.**

Notify parents/guardian and document what happened in the First Aid and Medication Logs.
***By law, a completed and signed Medication Form must be on file at the school before medication can be administered at school.**

CALL 911 if student has

- **Seizure of 5 minutes or longer duration.**
- **Two or more consecutive (without a period of consciousness between) seizures which total 5 minutes or greater**
- **Unusually pale or bluish skin/lips or noisy breathing after the seizure has stopped.**
- **If administering seizure medication.**

Administer CPR if Pulse or Breathing Stops!

Continue Until Paramedics Arrive!

Per SB 161, I understand that additional forms may be needed for diastat to be administered at school.
I authorize school personnel to implement this Seizure Emergency Care Plan as described.
I have completed a medication form FOR EACH medication needed at school.

_____ _____
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 to communicate with the authorized health care provider when necessary.

_____ _____
Parent/Caregiver Signature **Date**