Seizure Management and Treatment Plan Form

This form is designed to help create a plan for managing student seizures. It consists of several questions about seizure history, medications, precautions, and other considerations. Please fill out the form and provide it to the campus nurse or other appropriately identified personnel. If filling out the form by hand, write on the back or add additonal pages as needed for more space.

Student name: _____ **Date of birth:** _____ **Date:** _____

Name of parent or guardian: _____ **Phone:** _____

Email: _____

Name of treating physician: _____ **Phone:** _____

Email: _____

Emergency contact: _____ **Relationship:** _____

Phone: _____ **Email:** _____

1. Describe the medical history significant to the student's disorder (i.e., genetic, illness, injury, unknown):

Student name: _____	Date of birth: _____	Date: _____

2. Describe each type, length, and frequency of seizure the student has experienced:

3. Describe each type of seizure the student has experienced:

Student name: _____	Date of birth: _____	Date: _____

4. What are the student's seizure triggers or warning signs?

5. Describe the student's ability to manage seizures and their level of understanding of the seizures:

Student name: _____	Date of birth: _____	Date: _____

6. What is the student's response after a seizure?

7. What is the basic first aid and care provided to the student during a seizure?

Student name: _____	Date of birth: _____	Date: _____

8. Does the student need to leave the classroom after the seizure? Yes ☐ No ☐

If yes, please explain:

9. What is the process of the student's return to the classroom following a seizure (if applicable)?

Student name: _____	Date of birth: _____	Date: _____

10. Describe what constitutes a seizure emergency for the student:

11. Describe emergency protocol for district personnel to follow in the event of a student seizure:

Student name: _____	Date of birth: _____	Date: _____

12. Describe the student's medication guidelines and other protocols and procedures to be administered by the district personnel during school hours:

13. List each daily medication taken for seizure management including its name, dosage, and time the medication is given. Also, list common medication side effects and any special instructions.

Medication Name	Dosage	Time to be Given	Common Side Effects	Special Instructions

Student name: _____	Date of birth: _____	Date: _____

14. Does the student have a vagus nerve stimulator? Yes ☐ No ☐

If yes, what is the treatment protocol for appropriate magnet use?

15. Does the student have any special considerations or precautions applicable in relation to their seizure disorder?

Signature of Student's Parent/Guardian

Print Name

Signature of Treating Physician

Print Name