

# INDIVIDUALIZED HEALTH CARE PLAN

Livonia Public Schools

Confidential

Name:	School Year:
Health Concern: <b>SEIZURE DISORDER</b>	
Date of Birth:	Student ID:
Case Manager:	Ext:

Click Here to  
Add Picture

Seizure Triggers or Warning Signs \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Seizure Type	Length	Frequency	Description

Student's Response after a Seizure \_\_\_\_\_

\_\_\_\_\_

## ~ BASIC SEIZURE FIRST AID ~



Cushion Head



Loosen Neckwear



Turn on Side



Nothing in Mouth



Don't Hold Down

Stay calm and track the time until the child is fully conscious. Record the seizure in log.

## A SEIZURE IS GENERALLY CONSIDERED AN EMERGENCY WHEN:

- ⊕ Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- ⊕ Student has repeated seizures without regaining consciousness
- ⊕ Student is injured or has diabetes

- ⊕ Student has a first-time seizure
- ⊕ Student has difficulties breathing
- ⊕ Student has a seizure in water

## A SEIZURE EMERGENCY FOR THIS STUDENT IS DEFINED AS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## WHAT TO DO IN AN EMERGENCY:

- ⊕ Call 911 for transport
- ⊕ Notify parent or emergency contact
- ⊕ Administer emergency medication as indicated below

Emerg Med (✓)	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a Vagus Nerve Stimulator? ☐ Yes ☐ No If YES, describe magnet use: \_\_\_\_\_

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## Special Considerations & Precautions (regarding school activities, sports, trips, etc.)

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## Contact Information

Parent/Guardian \_\_\_\_\_

Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Other Contact \_\_\_\_\_

Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Student's Doctor \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

The following individuals have reviewed this Health Care Plan and support its implementation.

\_\_\_\_\_  
Parent / Guardian Signature      Date      Administrator Signature      Date      Doctor Signature (required)      Date