



# HUMBLE ISD HEALTH SERVICES

## SEIZURE MANAGEMENT PLAN

STUDENT \_\_\_\_\_ ID \_\_\_\_\_ GRADE \_\_\_\_\_ DOB \_\_\_\_\_  
 PARENT \_\_\_\_\_ PHONE \_\_\_\_\_ (2) \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_  
 MEDICAL HISTORY (OTHER THAN SEIZURES) \_\_\_\_\_

### SEIZURE INFORMATION

TYPE	LENGTH	FREQUENCY	DESCRIPTION

Warning signs \_\_\_\_\_

### Medications:

DAILY MEDICATION	STRENGTH	DOSE	ROUTE	TIME	OTHER INFO

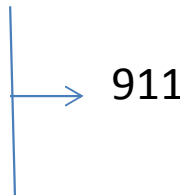
### General procedure

- Remain calm
- Notify the nurse
- Track time – Seizure Flow Sheet
- Lay the student on side
- Clear area of harmful objects
- Do not Restrain
- Monitor vital signs
- After \_\_\_\_\_ call 911
- Initiate CPR if necessary
- Observe for beginning of another seizure

### EMERGENCY PROTOCOL –

When seizure (tonic/clonic) last more that 5 minutes  
 Repeated seizure without regaining consciousness

- Student is injured
- Respiratory Distress
- First time Seizure
- Student is injured



911

### EMERGENCY MEDICATION –IF AVAILABLE

Medication	Strength	Dose	Route	Other Info

Student has a **Vagus Nerve Stimulator (VNS)**

**Magnet Orders** \_\_\_\_\_  
 \_\_\_\_\_

Physician \_\_\_\_\_ Date \_\_\_\_\_

Parent signature below indicates consent to administer medication above and consent for Humble ISD staff to communicate with the physician listed above regarding any aspect of the student’s care plan

Parent \_\_\_\_\_ Date \_\_\_\_\_  
 Signature

