Edinburg Consolidated Independent School District
Health Services
SEIZURE RESPONSE PLAN

Name: ______________________ Birth Date: ______________

Address: ______________________ ID # ______________

1st Emergency Contact /Relation: ______________________ Phone: ______________

2nd Emergency Contact / Relation: ______________________ Phone: ______________

Seizure Type/Nickname	What Happens	How Long It Lasts	How Often

Triggers

____

____

Daily Seizure Medicine

Medicine Name	Total Daily Amount	Amount to give	How Taken (time of each dose and how much)

Other Seizure Treatments

Device Type: ______________ Model: ________ Serial# ________ Date Implanted ______________

Dietary Therapy: ______________________ Date Begun: ______________

Special Instructions: ____

____

Other Therapy: ____

____

continued on back

Seizure First Aid

- Keep calm, provide reassurance, remove bystanders
- Keep airway clear, turn on side if possible, nothing in mouth
- Keep safe, remove objects, do not restrain
- Time, observe, record what happens
- Stay with person until recovered from seizure
- Other care needed: ______________________________

Call 911 if...

- Generalized seizure longer than 5 minutes
- Two or more seizures without recovering between seizures
- "As needed" treatments don't work
- Injury occurs or is suspected, or seizure occurs in water
- Breathing, heart rate or behavior doesn't return to normal
- Unexplained fever or pain, hours or few days after a seizure
- Other care needed: ______________________________

When Seizures Require Additional Help

Type of Emergency (long, clusters or repeated events)	Description	What to Do

"As Needed" Treatments (VNS magnet, medicines)

Name	Amount to Give	When to Give	How to Give

Health Care Contact

Epilepsy Doctor: ______________________________ Phone: ______________________

Nurse/Other Health Care Provider: ______________________________ Phone: ______________________

Preferred Hospital: ______________________________ Phone: ______________________

Primary Care: ______________________________ Phone: ______________________

Pharmacy: ______________________________ Phone: ______________________

Special Instructions: ____

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Parent signature ______________________________ Date ______________

Provider signature ______________________________ Date ______________

PLEASE RETURN FORM TO THE SCHOOL NURSE OR FAX ____________________

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