Community High School District #128

Libertyville High School
847-327-7016
Fax: 847-327-7933

Vernon Hills High School
847-932-2040
Fax: 847-932-2188

Seizure Management Plan

TO BE COMPLETED BY PARENT(S):

Date:________________________

________________________________ ________ ___________________________________
Student Grade Teacher

________________________________ ____
Mother's Name & Day Time Phone Father's Name & Day Time Phone

________________________________ ____
Physician treating condition Address

____
Physician Phone Fax

TYPE(S) OF SEIZURE: ____

DESCRIPTION OF TYPICAL SEIZURE

Body involvement: ____

Average Duration: ____

Frequency (daily, weekly, other): ____

Usual times of day: ____

Behavior/warning prior to seizure: ____

Student response to seizure: ____

Care needed during seizure, aside from typical precautions: ______________________________

____

Care needed after seizure:

- ☐ Rest in nurse's office
- ☐ Other: ____

Daily Medication

MEDICATION	DOSE/ROUTE	TIME	POSSIBLE SIDE EFFECTS

Student Name: ____

Physical Education/Team Sports:

- ☐ Full participation, no limitations
- ☐ Participation with the following modifications: ____
____

Emergency Intervention:

- ☐ If seizure lasts longer than ___________minutes, then __________________________________
- ☐ If _________ or more seizures occur in a row, then _____________________________________
- ☐ If seizure occurs on the bus, then ____
- ☐ Other: ____

Instructions:

- ☐ Seizure Observation record (as needed) to be completed by staff during school and shared with parents on a ________________interval.
  (weekly/Monthly)
- ☐ If school is unable to reach parents in an emergency, permission is granted to contact physician listed above.
- ☐ I/We agree to release this information to the following staff, with the expectation that confidentiality will be respected at all times:
  - ☐ Nurse
  - ☐ Teachers
  - ☐ LST (counselor, social worker)
  - ☐ After school caregivers/coaches
  - ☐ Bus Personnel
  - ☐ Other: ___________________

Additional Comments: ____
____
____

________________________________ ____________
Parent(s) Signature **Date**

________________________________ ____________
Physician(s) Signature **Date**

Return this form to:

Vernon Hills High School
Nurse's Office
145 N. Lakeview Parkway
Vernon Hills, IL 6061
Ph:847-932-2040 Fax: 847-932-2188