

Birmingham Covington School

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1525 Covington Road, Bloomfield Hills, MI 48301

Dear Parent/Legal Guardian:

You have indicated that your child has **seizures**.

For school personnel to provide daily and emergency management of your child's seizures at school, please complete the following forms:

- 1. Emergency Care Plan for a Seizure Disorder**
- 2. BPS Permission to Administer Medication form**
- 3. Parent/Legal Guardian Questionnaire**

Enclosed you will find the appropriate forms to complete and return to the school office.

It is the parent/legal guardian's responsibility to provide all prescribed medications to the school. Please be advised that you are responsible for annual updates, and for changes as they occur throughout the year.

If an emergency arises before receipt of an individual Care Plan, school district procedures regarding seizures will be followed.

Please return the enclosed forms to the school office by on or before the first day of school.

For further information or concerns, please contact the Public Health Nurse at the Oakland County Health Division, 248-424-7180.

Sincerely,

Adam Hartley

SEIZURE DISORDER EMERGENCY CARE PLAN

STUDENT NAME: _____ TEACHER: _____

ADDRESS: _____ GRADE/ROOM _____

PARENT/LEGAL GUARDIAN:

NAME: _____ HOME#: _____ WORK#: _____ OTHER#: _____
NAME: _____ HOME#: _____ WORK#: _____ OTHER#: _____

This student has a seizure disorder, which places him/her at risk for experiencing a seizure requiring emergency response. The following emergency plan is based on physician's recommendations (Physician, please add or delete any steps). Child's symptoms usually are: _____

PLEASE FOLLOW THESE STEPS IF SEIZURE OCCURS:

- Remain with child
- Ease student to floor
- Cushion head
- Loosen tight neckwear
- Turn on side
- Do not put anything in mouth
- Do not hold down

OBSERVE CHILD FOR 5 MINUTES

↓
IF SYMPTOMS IMPROVE:

- Give reassurance
- Notify Office
- Notify parent/legal guardian

↓
IF SYMPTOMS DO NOT IMPROVE
(slow recovery, 2nd seizure, difficulty breathing after seizure, lasts more than 5 minutes)

- Call 911
- Notify Office
- Notify parent/legal guardian

Physician's Signature _____ Date _____

Parent/Legal Guardian Signature _____ Date _____

PARENT/LEGAL GUARDIAN QUESTIONNAIRE REGARDING EPILEPSY/SEIZURE DISORDER

Dear Parent/Legal Guardian of: _____

Our records indicate that your child has a seizure disorder. Please respond to the following questions in order to provide first aid if your child experiences a seizure during school hours.

Please return the completed form by _____.

1. At what age did your child have his/her first seizure? _____
2. Seizure type: _____
3. Describe what typically happens during the seizure: _____

4. What triggers the seizure? _____
5. How long does it last? _____
6. How long should the student wait after the seizure before returning to the regular school schedule? _____
7. Are there any warnings and/or behavior changes before the seizure? _____

8. How often does your child have a seizure? _____
9. Usual time of day seizure(s) occur: _____
10. Date of last seizure: _____
11. Describe first aid treatment given for seizures at home: _____

12. Student's reaction to seizure(s): _____
13. How do other illnesses affect your child's seizure control? _____

14. What medication(s) does your child take?

Medication	Dosage	Frequency & Time of Day Taken (AM/PM)

OVER
7-4.3a

STUDENT INTERVIEW FORM

Student's Name: _____ Age: _____ Grade: _____
 Date Completed: _____

1. What kind of seizure(s) do you have? _____
2. How old were you when your seizures began? _____
3. Do you have any special feelings when a seizure is about to occur? If yes, please explain: _____

4. What, if anything, makes it more likely you will have a seizure? List.

5. Describe how you usually feel after a seizure:

6. How often do you have a seizure? _____
7. When do they occur most often? (i.e. During night time, upon waking, etc.)
8. When was your last seizure? _____
9. What medication(s) do you take?

Medication	Dosage	Frequency & Time of Day Taken (AM/PM)

10. What do you do if you miss a dose of medication? _____

11. Check any of the following school related activities that may be affected by your seizure disorder:

Gym Class _____	Lunch _____	Field Trip _____
Sports _____	Recess _____	Transportation _____

 Other (Please Specify) _____
 Describe limitations: _____
13. Do you attend any educational sessions regarding seizure disorders? _____
14. Are you involved in any support group related to seizure disorders? _____

EMERGENCY RECORDING FOR A SEIZURE

Student's Name _____ Date _____

Staff's Name/Title _____

1. Approximate time of onset: _____

2. Student's activities immediately preceding seizure: _____

3. Description of seizure or behavior: _____

4. Student's behavior after seizure: _____

5. How long did seizure last? _____

6. Were there any injuries? YES NO If yes, describe:

7. Actions taken by teacher/observer: _____
