

Student Transportation:  
(Please check)  
 Bus Rider  
 Bus No. \_\_\_\_\_  
 Parent pickup



# ALPHA ACADEMY SEIZURE CARE PLAN

DATE: \_\_\_\_\_

School Name: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age when diagnosed: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

What type of seizure does child have? \_\_\_\_\_

How long has it been since his/her last seizure? \_\_\_\_\_ How often do the seizures occur? \_\_\_\_\_

Does child experience an aura or have a trigger before a seizure:  Yes  No If yes, please describe: \_\_\_\_\_

LIST MEDICATION	DOSE/AMOUNT TAKEN	TIME	WILL MEDICATION BE NEEDED AT SCHOOL?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Does the student have a Vagus Nerve Stimulator (VNS)?  Yes  No If, yes where is magnet worn? \_\_\_\_\_

Describe the use of the magnet: \_\_\_\_\_

Does your child have a Section 504 Plan?  Yes  No Does your child have an Individual Education Plan (IEP)?  Yes  No

**Children with Disabilities:** It is and shall remain the policy of Alpha Academy not to discriminate on the basis of gender or disability in its educational programs, activities, or employment policies as required by Title IX of the 1972 Educational Amendments, the 1990 Americans with Disabilities Act, and Section 504 of the Rehabilitation Act of 1973. It is the policy of Alpha Academy to provide equal employment opportunities on a nondiscriminatory basis, regardless of sex, race, age, national origin, disability or religion. The individual designated to ensure district compliance with Section 504 is the Executive Director of Student Services, phone (910)223-7711

**Release of Liability:** Realizing the importance of administering medication to my child as prescribed by the child's physician, do hereby agree to relieve designated school personnel, and Alpha Academy of and from any liability from any potential ill effects as a result of their injecting or giving my child medication prescribed by the child's physician. I have discussed this with my physician and/or legal counsel (lawyer) and realize its ramifications and thoroughly understand the meanings of these statements. I consent for the medical provider to disclose health or medical information regarding medication prescribed. I understand that I may revoke this consent at any time, except to the extent action has been taken in reliance on it. This consent is valid until I revoke it in writing or for the term of one year. **Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### SIGNS OF SEIZURES: Please check ALL behaviors that apply.

SIMPLE SEIZURES	GENERALIZED SEIZURES	DANGER SIGNS: CALL 911	BEHAVIORS EXPECTED AFTER SEIZURE	
<input type="checkbox"/> Lip smacking <input type="checkbox"/> Behavioral outburst <input type="checkbox"/> Staring <input type="checkbox"/> Twitching <input type="checkbox"/> Other: _____	<input type="checkbox"/> Sudden cry or squeal <input type="checkbox"/> Falling down <input type="checkbox"/> Rigidity/stiffness <input type="checkbox"/> Thrashing/jerking <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Loss of bowel or bladder control <input type="checkbox"/> Gurgling or grunting noises <input type="checkbox"/> Other: _____	<input type="checkbox"/> Stops breathing <input type="checkbox"/> Blue color to lips <input type="checkbox"/> Froth from mouth <input type="checkbox"/> Shallow breathing	<input type="checkbox"/> Seizure lasts more than 5 minutes <input type="checkbox"/> Another seizure starts right after the 1st seizure <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Stops breathing <input type="checkbox"/> If the student has diabetes <input type="checkbox"/> If the seizure is the result of an injury or child is injured during the seizure <input type="checkbox"/> If the student is pregnant <input type="checkbox"/> If the student has never had a seizure before <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tiredness <input type="checkbox"/> Weakness <input type="checkbox"/> Sleeping, difficult to arouse <input type="checkbox"/> Somewhat confused <input type="checkbox"/> Regular breathing <input type="checkbox"/> Other: _____
<b>All of the above can last a few minutes to a few hours.</b>				

**IF YOU SEE THIS** Stay calm. Move surrounding objects to avoid injury. Do not hold the student down or put anything in the mouth. Loosen clothing as able. After seizure stops, roll student on his/her side. If applicable, administer medications as ordered. Notify the parent/guardian and document seizure activity on the back of this form.

Stops breathing	Begin CPR/rescue breathing. Call 911	<b>MD Stamp Below</b>
Loss of bowel or bladder control	Cover with blanket or jacket and if necessary, assist with changing of clothes after seizure.	
Falls down or loss of consciousness	Help the student to the floor for observation and safety.	
Vomiting	Turn on to their side.	

SIGNATURES	DATE	PARENT/GUARDIAN SIGNATURE	NURSE SIGNATURE	TEACHERS' SIGNATURE OF ACKNOWLEDGMENT
Plan Initiated				
1st Review				
2nd Review				

Copy: Director of Health Services      Public Health School Nurse      If applicable copy:  
 504 Coordinator      Cum. Folder      Special Needs Nurse  
 EC Case Manager      School Bus Driver

# ALPHA ACADEMY SEIZURE OBSERVATION RECORD

Student Name:						
Date & Time						
Seizure Length						
Pre-Seizure Observation: (Briefly list behaviors, triggering events, activities)						
Conscious (yes/no/altered)						
Injuries (briefly describe)						
Muscle Tone/Body Movements	Rigid/clenching					
	Limp					
	Fell down					
	Rocking					
	Wandering around					
	Whole body jerking					
Extremity Movements	(R) arm jerking					
	(L) arm jerking					
	(R) leg jerking					
	(L) leg jerking					
	Random Movement					
Color	Bluish					
	Pale					
	Flushed					
Eyes	Pupils dilated					
	Turned (R or L)					
	Rolled up					
	Staring/blinking					
	Closed					
Mouth	Salivating					
	Chewing					
	Lip smacking					
Verbal Sounds (gagging, slurred speech, throat clearing, etc.)						
Breathing (normal, labored, irregular, noisy, etc.)						
Incontinent (urine or feces)						
Post-Seizure Observation	Confused					
	Sleepy/tired					
	Headache					
	Speech slurring					
	Other					
Length of time until awake and alert?						
Parents notified? (time of call)						
EMS called? (time of call & arrival time)						
Signature of Trained Personnel	1.		3.		5.	
	2.		4.		6.	