Pittsburgh Public Schools
Expect great things.

REV 9-18

PITTSBURGH PUBLIC SCHOOLS – HEALTH SERVICES

SEIZURE PLAN FOR SCHOOL

Enter School Year_____ **Enter Current Date**_____

LAST NAME	DOB
FIRST NAME	GENDER
SCHOOL	GRADE

DATE OF LAST SEIZURE_____

PLEASE DESCRIBE ALL SEIZURE PRESENTATIONS, TYPICAL LENGTH, COMPLICATIONS, ETC.
(Example: The most common seizures are staring spells occasionally accompanied by chewing mouth movements and turning of the head to the left side. Duration-usually last less than 5 minutes. Afterward, student may be a little sleepy. Student may also have tonic clonic seizures lasting less than 2 minutes.)

Are there any warnings and /or behavioral changes before a seizure occurs? Yes ☐ OR No ☐ If yes, describe:

What triggers for seizures should be avoided in school if possible?

MEDICATIONS:

Are there restrictions or limitations of any school activities (gym, sports, other)? Yes ☐ OR No ☐ If yes, describe:

For Tonic Clonic seizure activity in school:

1. The student should be carefully placed on their side, and start timing the seizure.
2. Cushion and protect their head and place nothing in the student's mouth.
3. 911 should be called if the seizure lasts longer than 5 mins. and/or is an unusual occurrence.
4. The school nurse should be informed, and if possible come to the scene.
5. The area should be cleared of nonessential personnel.
6. The parents should be called.

✖ _____ ✖ _____ ✖ _____

NEUROLOGIST SIGNATURE **PRINT NAME** **DATE**

DATE **PHONE** **FAX**

✖ _____

PARENT/GUARDIAN SIGNATURE **PRINT NAME** **DATE**

CHECK THE BOX FOR THE BEST NUMBER TO REACH YOU.	**HOME** ☐	**OTHER** ☐

PARENT/GUARDIAN: PLEASE COMPLETE A RELEASE OF INFORMATION FORM WITH YOUR CHILD'S NEUROLOGIST SO THAT THE SCHOOL NURSE MAY DISCUSS IMPLEMENTATION OF THIS PLAN WITH THE PHYSICIAN.