

**CARROLL COUNTY PUBLIC SCHOOLS
SEIZURES**

Name: _____

Date: _____

You have indicated on the Emergency Card that your child has a seizure disorder. In order for school personnel to respond to this quickly and effectively, additional information is necessary. The information will be shared with those individuals that have a need to know.

Date of Last Seizure: _____ **Date of Last Hospitalization for Seizure:** _____

Are medications needed to control the seizures? Yes No (List below.)

MEDICATION	AMOUNT TAKEN	TIME OF DAY	COMMENTS

PLEASE ADVISE THE NURSE IMMEDIATELY OF CHANGES IN DOSE AND/OR TYPE OF MEDICATION!

Circle those appropriate:

Warning signs before a seizure starts:

Headache Odor Sight or Hearing Disturbance Other: _____ None

What happens during a seizure?

Mental State: Confused Unconscious Dreamlike / Vacant / Staring Unchanged

Loss of Control: Bladder Bowel **Breathing:** Normal Noisy Interrupted

Muscle Tone: Rigid (Whole body, specific part of body): _____ Falls Down

Decreased muscle tone (weakness) Spasms / Tremors (Shaking)

Other: _____

Movement: Jerking (whole body, specific part of body): _____

Purposeful movement Wandering

Eyes: Change in eyes: Yes _____ No _____ Explain: _____

Other: Slurred speech Head drops Vomiting Other: _____

How long does the seizure normally last? _____

What happens after the seizure?

Irritable Confused Stomachache Headache Drowsy Deep Sleep Normal

How do you want the school to respond in the event of a seizure?

Call every time Rest Return to Class Send Home Other: _____

Does your student need any special activity adaptation/protective equipment at school?

Yes No Describe: _____

Comments: _____

Parent/Guardian Signature: _____

***Seizures lasting longer than 5 minutes or are different (more severe) than usual will result in a 911 call.**