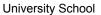
INDIVIDUALIZED HEALTH PLAN, SEIZURES

WASHINGTON COUNTY DEPARTMENT OF EDUCATION COORDINATED SCHOOL HEALTH





Phone: (423) 439-8674 Fax: (423) 439-5921

CONFIDENTIAL			
STUDENT:	DOB:	TEACHER:	GRADE
ARE MEDICTIONS NEEDED TO CONT MEDICATIONS (name, dose, time(s) ta	ıken):		
IF FALLING/GENERALIZED JERKING:			
 Assist student to floor, turn to le Notify Nurse/First Responder/O Delegate call to EMS/911. 	ffice		
IF SEIZURE OF ANY TYPE OCCURS:1. Loosen clothing at neck and wai with arms, lap, cushioning mater		(if applicable); protect head	
 Clear away furniture and other o Have another classroom adult re TIME THE SEIZURE. 	bjects from area.	rom area.	
Allow seizure to run its course; Deputy purposeless behavior.		-	
 During a general or grand mal se hear noisy breathing. Remain calm. 	eizure expect to see pa	ale or bluish discoloration of tr	ie skin/lips. Expect to
IF FOCAL MOTOR OR SMALLER LOCA		IP SMACKING, BEHAVIOR (OUTBURST)
 Assist student to comfortable/sitti Time the seizure. 	• .		
IF STUDENT EXHIBITS:			
Absence of breathing and/or pulse	e.		
Seizure of 5 minutes or greater du	ıration.		
3. Two or more consecutive (without	a period of consciousr	ness between) seizures which	1 total 5 minutes or
greater.	:4		
4. No previous history of seizure acti5. Continued unusually pale or bluisl		athing after the seizure has st	onned
DO:	1 Skiri/lips of Holsy brea	duning after the seizure has so	oppea.
<u>50.</u>			
 Delegate call to EMS/911 immedia Start CPR for absent breathing/pul 		I notify parent.	
Any additional information specific to	this student:		
	Exercise and Sports P	articipation Guidelines	
[] NO RESTRICTIONS—Includes interscho [] MODERATE EXERCISE—Includes phys			avoid activities which
require maximum or sustained effort. [] LIGHT EXERCISE—Includes nonstrenuc program without being graded recomme	ended).	5.7 55 5:	g, (modified gym
[] Must be permitted to determine his/her o [] NO PHYSICAL EDUCATION CLASSES		stop and rest if needed.	
This Individualized Health Plan will Health Staff. It is the parent's res necessary (i.e. teachers, coaches,	ponsibility to share	this information with ot	her staff you deem
agreement with this policy.	oto.j. Tour signatt	are below mulcates your	understanding and
Physician Name:			
Phone:		Parent Signature	Date
Physician Signature	 Date	Parent Contact	Phone