Klamath County School District

Health Services

Inspiring Today's Students To Meet Tomorrow's Challenges

2845 Greensprings Drive • Klamath Falls, OR 97601 • 541-883-5000 • FAX 541-885-3366

SEIZURE INFORMATION FORM

Student's Name: _____ Date of Birth: _____
Parent/Guardian: _____ Phone: _____ Cell Phone: _____
Allergies: _____
Last Seizure: _____ Medication (daily): _____
Emergency medication needed at school: Diastat_____ Versed _____ Other _____

SEIZURE INFORMATION:

□ Petit mal (Absence type) - Short staring spells /may drop object (s)he is holding
□ Grand mal - Jerking and stiffening of the arms and legs with loss of consciousness
□ Complex partial - Glassy stare, confusion, picks at clothing, smacking lips or other repetitive movements
□ Other _____
□ Student has a **Vagus Nerve Stimulator (VNS)** (Refer to separate VNS plan)
□ Student has seizure triggers_____
□ Student has warning signs of imminent seizure activity_____
□ Seizure is likely to occur at school
□ Student will need a place to rest following a seizure.
□ Student may resume school activities after recovering

GUIDELINES FOR SCHOOL ACTIVITIES

PE/Sports/Playground

□ No swings/climbing equipment higher than _____ □ No swimming □ No contact sports

Field Trips

Seizure trained staff /relative to go Medication trained staff/relative to go if meds will be needed

Academics

□ No operation of mechanical equipment e.g. tractors, jig saws ☐ No academic restrictions

Absences

Teachers will provide for homework and make up test times if absent due to medical condition

Other

- Copy of plan to appropriate school staff
- Substitute teacher alert in "sub" notebook
- Copy of plan to go on field trips

Medical Provider _____ Clinic _____ Date _____

School District Nurse: _____

Reference: www.epilepsyfoundation.org rev 8/18 rnh