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

CUMBERLAND COUNTY SCHOOLS
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?
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐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 Cumberland County Board of Education 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 the Cumberland County Board of Education to provide equal employment opportunities on a nondiscriminatory basis, regardless of sex, race, age, national origin, disability or religion. Cumberland County Board of Education Policy 1730/4022/7231. The individual designated to ensure district compliance with Section 504 is the Executive Director of Student Services, phone (910) 678-2433, and the mailing address is Cumberland County Schools, PO Box 2357, Fayetteville NC 28302.

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, the Cumberland County Schools, and the Cumberland County Board of Education 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
☐ Lip smacking ☐ Behavioral outburst ☐ Staring ☐ Twitching ☐ Other: ____________ ____________ ____________	☐ Sudden cry or squeal ☐ Falling down ☐ Rigidity/stiffness ☐ Thrashing/jerking ☐ Loss of consciousness ☐ Loss of bowel or bladder control ☐ Gurgling or grunting noises ☐ Other: ____________ ☐ Stops breathing ☐ Blue color to lips ☐ Froth from mouth ☐ Shallow breathing	➢ Seizure lasts more than 5 minutes ➢ Another seizure starts right after the 1st seizure ➢ Loss of consciousness ➢ Stops breathing ➢ If the student has diabetes ➢ If the seizure is the result of an injury or child is injured during the seizure ➢ If the student is pregnant ➢ If the student has never had a seizure before ➢ Other:	☐ Tiredness ☐ Weakness ☐ Sleeping, difficult to arouse ☐ Somewhat confused ☐ Regular breathing ☐ Other: ____________ ____________ **All of the above can last a few minutes to a few hours.**

IF YOU SEE THIS		MD Stamp Below
	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	
Loss of bowel or bladder control	Cover with blanket or jacket and if necessary, assist with changing of clothes after seizure.	**Physician's Signature and Date**
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
504 Coordinator
EC Case Manager
Public Health School Nurse
Cum. Folder
If applicable copy:
Special Needs Nurse
School Bus Driver

CUMBERLAND COUNTY SCHOOLS
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.	