HEAD START/EARLY HEAD START
Tri-County Community Council, Inc.
2499 Cypress St. Westville, Fl 32464
(850) 548-9900 FAX (850) 548-5644

School Year
20__-20__

Page 1 to be completed by Parent/Guardian
Please Print

SEIZURE DISORDERS

Child Information: Center: ____________________

Name of Child: ____________________ **Date of Birth:** ____________________

Child's Age: ____________ **Teacher:** ____________________

Emergency Information

Parent(s') or Guardian(s') Names: ____________________

Mother's Telephone (W): ____________________ **Father's Telephone (W):** ____________________

Pager: ____________________ **Pager:** ____________________

Telephone (H): ____________________ **Telephone (H);** ____________________

Neurologist: ____________________ **Telephone:** ____________________

Primary Care Physician: ____________________ **Telephone:** ____________________

In the event a parent/guardian cannot be reached:

1. ____________________ **Relation:** ____________ **Telephone:** ____________

2. ____________________ **Relation:** ____________ **Telephone:** ____________

Triggers that may bring on a seizure: ____________________

Signs and symptoms: (Please check the symptom(s) that occur in your child.)

- ☐ 1. Aura (symptoms before seizure: ____________
- ☐ 2. Generalized convulsions involving entire body
- ☐ 3. Pallor or skin discoloration
- ☐ 4. Labored (noisy) breathing
- ☐ 5. Dilation of pupils
- ☐ 6. Loss of consciousness: may fall to ground
- ☐ 7. Involuntary loss of urine or feces
- ☐ 8. Staring/blank gaze/day dreaming
- ☐ 9. Other: ____________

Is your child aware of impending seizure activity? ____Yes ____No

My child has the following other chronic illnesses/disabilities: ____________________

Allergies: ____________________

Child's Limitations or Special Considerations: ____________________

ALL CURRENT MEDICATIONS

Name of Medication	Dosage and Strength	Purpose	Day Schedule	Time of Day

I understand that it is my responsibility to keep this information current. Please notify the Center Coordinator/Family Service Worker and provide an updated/current form on at least an annual basis. Parent Signature____________________**Date**____________

rk7/11/11

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Page 2 to be completed by Physician

Child's Name: ______________________________

SEIZURE DISORDERS

EMERGENCY FORM FOR A SEIZURE

DURING SEIZURE ACTIVITY
1. STAY WITH THE CHILD
2. a. If falling or generalized jerking occurs, place child on floor.
b. Gently support head to side position and monitor breathing and pulse.
c. DO NOT restrain child. DO NOT try and place anything in child's mouth or between child's teeth.
d. Protect child by moving items away that may cause injury – e.g. desks, chairs.
e. Loosen clothing at neck and waist; remove eyeglasses (if applicable).
3. Have another classroom adult remove/direct students from the area.
4. Use watch. TIME THE SEIZURE. Observe pattern of the seizure and be prepared to describe it.
5. CALL 9-1-1 IF CHILD EXHIBITS:
a. Absence of breathing and/or pulse (Start CPR for absence of breathing and pulse)
b. Seizure of 5 minutes or greater duration.
c. Two or more consecutive (without a period of consciousness between) seizures which total 5 minutes or greater.
d. No previous history of seizure activity.
e. Continued unusually pale or bluish skin/lips or noisy breathing after a seizure has stopped.
Preferred Local Emergency Department ____
AFTER SEIZURE ACTIVITY
1. Reorient and assure child.
a. Allow/assist change into clean clothing if necessary.
b. Allow child to sleep, as desired, after seizure.
c. Allow child to eat, as desired, once fully alert and oriented.
2. A child recovering from a generalized seizure may manifest abnormal behavior such as incoherent speech, extreme restlessness, and confusion. This may last from 5 minutes to hours.
3. Inform parent immediately of seizure by telephone if:
a. Seizure is different from usual type/frequency/has not occurred at school in the past month.
b. Seizure meets criteria for 9-1-1 emergency call.
c. Child has not returned to "normal self" after 30/60 minutes.
It is the parent's responsibility to determine follow-up care for symptoms.
Individual considerations: ____

____

____

This child also has the following chronic illnesses/disabilities: ______________________________

____

Physician: ____

Physician's signature: ______________________________________ **Date:** ______________