HEALTH CARE/EMERGENCY PLAN (SIEZURES) CHATFIELD PUBLIC SCHOOLS

STUDENT INFORMATION:

Student Name:_____ School:_____
Date of Birth:_____ Grade:_____

CONTACTS:
Parent/Guardian: _____ Home Phone:_____
Work: _____ Cell/pager:_____ Other: _____
Physician/Clinic: _____ Phone # _____

MEDICATIONS: Home School
Name:_____ Dose:_____ Time:_____ ____ _____
Name:_____ Dose:_____ Time:_____ ____ _____
Name:_____ Dose:_____ Time:_____ ____ _____
Name:_____ Dose:_____ Time:_____ ____ _____
ALLERGIES:_____

SEIZURE INFORMATION:
1. Type of Seizure:_____
2. Last observed seizure (month & year)_____
3. Number of seizures in the past year: _____
4. Warning signs: _____
5. Length of typical seizure: _____
6. Parts of body involved (please describe):_____
   _____
   _____

TYPES OF LIMITATIONS:
- Play ground equipment ___ Yes ___No ___N/A
- Swimming ____ Yes __ No ____N/A
- Machinery operation ____ Yes __ No ____ N/A
- Other:
  _____
  _____

FIELD TRIP PLAN:
_____
_____

EMERGENCY PLAN OF CARE:
1. Call 9-1-1 and parent if:
   - Seizure is longer than ____ minutes
   - Student has one seizure after another
   - Student is having difficulty breathing.

FIRST AID FOR SEIZURES:

1. Call the School Nurse/ Secretaries Name:_____ ext _____
2. Gently protect the student from injury. Help him/her to lying position, preferably on side, place something soft under the head, loosen tight clothing and clear the area of hard or sharp objects
3. Stay with the student until full recovery has occurred. Allow the student to rest if needed.
4. Be reassuring and supportive when consciousness returns.
5. Document the following:
    - What happened before during & after the seizure
    - Time seizure began and the length of seizure.
    - What parts of the body were involved & how.

DO NOT:

- **FORCE ANY OBJECTS INTO THE PERSON'S MOUTH**
- **RESTRAIN MOVEMENTS**
- **OFFER FOOD OR LIQUIDS UNTIL FULLY AWAKE**

HOSTPITAL OF CHOICE: _____

Nursing Diagnosis:	Goals:
1. Potential for physical injury. 2. Potential for disturbance in self-concept & or social isolation.	1. Prevent physical injury during a seizure. 2. Acceptance of self to be a whole person & age appropriate social interaction.

I give the School Nurse permission to consult (both verbally & in writing) with the above named student's physician regarding any questions that arise about the medical condition and/or medications/treatments/procedures, being used to treat the condition. ____Yes ___ No

- Parent Signature: _____ Date: _____
- *Physician Signature: _____ Date: _____
- School Nurse: _____ Date: _____
- Principal :_____ Date: _____

*Physician signature required only if this form is used as a doctor's order for medication(s) or treatment(s)

- The school district intends to use the requested information to provide for your child's health and safety needs while at school.
- You may refuse to supply the requested personal information.
- If this form is not completed it may result in an incomplete health and safety plan for your child
- Medications are not administered at school without physician and parent signatures.
- The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety and school success.