Seizure Disorder

School Year: _____ Grade: _____

INDIVIDUAL HEALTH PLAN

Student Name: _____ DOB: _____
Parent/Guardian: _____ Phone: _____
Emergency Contact: _____ Phone: _____
Treating Physician: _____ Phone: _____

Type of Seizure Disorder:

- ☐ Absence
- ☐ General Tonic-Clonic (Grand Mal)
- ☐ Myoclonic-sporadic jerks
- ☐ Unspecified
- ☐ Clonic – repetitive jerks on both sides
- ☐ Tonic – stiffening of the muscles
- ☐ Partial simple – jerking, spasms, unusual sensations
- ☐ Partial complex – loss of awareness, repetitive, involuntary movements

Known Triggers:

☐ Flashing Lights, Computers, Electronic Games ☐ Hormonal, Emotional Stress or Anxiety ☐ Lack of Sleep
☐ Other: _____

Warning Signs or Auras Before a Seizure:

☐ Headache ☐ Vision Changes – blurred vision, double vision, spots, blinking lights ☐ Body Temperature (hot or cold)
☐ Other: _____

ACTION

1. *Ensure the safety of the student and the immediate environment, following standard seizure protocols.*
2. *Time, or designate someone to time the seizure.*
3. *If Emergency Medication is ordered, get or have someone get the medication ready to use.*
4. *Contact the parent/guardian per their instructions.*
5. *Document all seizure activity in the student health record.*
6. *Other:* _____

School Seizure Plan: If a conclusive seizure occurs during bus transportation or if emergency medication is used call 911.

Emergency Medication: _____ Dose: _____ Route: _____

Location of medication: ☐ Health Unit ☐ Medication must be with students at all times, or with an accompanying adult (requires 504)

Administer Emergency Medication for convulsive seizure activity longer than: ☐ 5 minutes ☐ 3 minutes

Please note: The school nurse does not always attend field trips or after school events/clubs/athletics. For this reason non-medical, unlicensed school staff members are trained to administer medication.

Prescription medication or treatment daily at school for this condition: _____
Prescription medication or treatment daily at home for this condition: _____
During a field trip, scheduled daily medication:
☐ requires a trained staff member to administer daily/at home medication
☐ is authorized to carry and self-administer daily/at home medication

X _____ _____ _____
Physician or Authorized Healthcare Provider Signature | Telephone Number | Date Signed

I am the parent/guardian of the above named student and give consent and permission for the information on this form to be shared with teachers, principals, and other staff members that have direct contact with my child for the current school year. I understand that a trained school staff member may administer prescribed medication and/or assist my child to comply with his/her physician's prescribed medications or treatments if needed. If my child's physician gives authorization for my child to carry and self-administer his/her medication, I consent and understand that medication independently self-administered is not monitored by staff. I agree to provide the necessary prescribed medication or treatment supplies and agree to notify the school nurse immediately of any changes.

The school health staff shall contact the student's parent/guardian to discuss any concerns regarding the student's care which might require medical follow-up and/or shall contact the health care provider to obtain current information verbally when necessary to manage the student's condition at school. I understand that the Rockcastle County Board of Education Medication Policy and Procedures are readily available for me to read.

I hereby agree to release and hold staff members free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment described by me or prescribed by my child's physician. I have read and understand this consent. I sign it voluntarily and with full knowledge of its significance.

X _____ _____
Parent/Guardian Signature | Date Signed