DEPARTMENT OF SCHOOL HEALTH SERVICES

Danville Independent Schools

TO: Parent/guardian of:_____
Birthday:_____Student ID number_____
Grade:_____School:_____

You have indicated on school records that this student has **seizures.** It is important to have at least yearly health information when s/he needs help at school. **Please fill out and return this form** to school **by tomorrow** so a plan to help your child can be shared with identified school staff. It is the responsibility of parents to provide necessary special medicine needed at school. If you have questions, you may call the nurse at your student's school.

How often do seizures occur?_____
Has s/he been hospitalized in the last year for seizures? [ ]No [ ] Yes When?_____
Seizures are currently being treated by Dr:_____Phone:_____
What does the seizure look like and how long does it usually last?_____
_____
List conditions which generally cause the seizure (ex: noise, blinking lights)_____
_____
Does your student need any special activity adaptations/protective equipment (ex. helmet) at school?
[ ]No [ ]Yes (describe)_____
How long after seizure before the student can return to his/her regular activities?_____
ARE MEDICATIONS NEEDED TO CONTROL THE SEIZURES? [ ]No [ ]Yes (list medicines below)

Medications	Amount taken	Time of day

Which medications need to be taken at school?(school policy should be followed):_____

PLEASE ADVISE THE SCHOOL AT ONCE OF CHANGES IN DOSE AND/OR TYPE OF MEDICINE

The usual procedure at school for a student having a seizure is:

1. Stay with the student through seizure.
2. Provide for student safety by removing nearby hazardous objects, loosening clothing at neck and waist, and protecting head from injury.
3. Remove other students from the immediate environment to give privacy as possible.
4. Observe student for inadequate breathing/continuous seizing; when seen call 9-1-1.
5. Advise parent of seizure.
6. Reorient the student and guide student to safe locality.
7. Provide rest as needed for student after the seizure.

If you want additional help given, or have other concerns, describe here: *_____
_____
_____

X_____
Parent signature **Date**

REMEMBER TO ADVISE THE SCHOOL IMMEDIATELY OF CHANGES IN PHONE NUMBERS, ADDRESS, RESPONSIBLE EMERGENCY CONTACT PERSONS, OR DOCTOR.

* tests and activity restrictions require written direction from the student's doctor.