Child Health Plan and Provider Orders - Seizure Disorder

Center:	☐ ECEAP	☐ Head Start	☐ Early Head Start
Child's Name:	**Date of Birth:**		Gender: ☐ M ☐ F
Parent/Guardian:	**Phone:** (Home)		(Cell)
Does this child have any of the following? (check one)	☐ IEP	☐ IFSP	☐ 504 Plan

Seizure Specialist: **Phone:** **Fax:**

Seizure Type:

Description:

Symptoms that signal or precede episodes:

Comments and/or special instructions:

Remember to do the following:

1. Stay with the child and call or send for extra help.
2. Position the child to avoid choking on saliva.
3. Clear the area around the child of hazards.
4. Do not put anything in the child's mouth.
5. Notify parents.
6. Call 911 if seizure lasts more than 5 minutes or if the child becomes blue or stops breathing.
7. Notify the front office after calling 911.
8. Other:

Is medication(s) taken at home? ☐ Yes* – List: ☐ No

***If yes, we will need a three-day supply at school in case of disaster.**

Does your child have emergency medication at home?* ☐ Yes ☐ No

***Staff cannot administer Diastat. If Midazolam is prescribed, staff have to volunteer to administer it.**

This page is to be completed by the Health Care Provider.

Child's Name: **Date of Birth:** **Gender:** ☐ M ☐ F

☐ **No medication is required at school (Skip box and sign below if you agree with this *Child Health Plan*).**

☐ **Medication is required at school (Fill out box and sign below). If medication is taken daily at home, a 3-day supply of medication is needed at school in case of a disaster.**

Health Care Provider Orders for Medication at School

Note: Teaching staff are not allowed to administer Diastat. If Midazolam is prescribed, it is up to the staff to volunteer to administer that medication.

Important notice to Provider:

Please ensure this child has a prescription on file with the pharmacy that matches the orders below.

Our policy requires Health Care Provider Orders and medication labels to match exactly.

1) Medication Name	**2) Symptoms for medication use**	
3) Dose	**4) Frequency & Length of time between doses**	**5) Route**
6) Possible side effects of medication		
7) Special administration and/or storage instructions		
8) If PRN, start date	**and end date**	**required.**

Health Care Provider Signature **Date**

Print Name **Phone #** **Fax #**

Parent/Guardian Signature **Date**

Interpreter Signature **Date**

Nurse Consultant Signature **Date**

ITE/Teacher **Date** **ITP/Assistant** **Date** **FA/FE/FSS/HV** **Date** **Dir/C Coor** **Date**