Seizure Disorder MCSD Individual Health Plan School Year: _____ Grade: ___

Student Name_____DOB_____
Parent/Guardian_____Phone_____
Emergency Contact_____Phone_____
Treating Physician_____Phone_____

Picture

Type of Seizure Disorder:

- ❒ Absence
- ❒ General Tonic-Clonic (Grand Mal)
- ❒ Myoclonic—sporadic jerks
- ❒ Unspecified
- ❒ Clonic-repetitive rhythmic 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 convulsive seizure occurs during bus transportation or if emergency medication is used

CALL 911

Emergency Medication: _____ **Dose:** _____ **Route:** _____

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

Location of medication: ❒ Nurse Office ❒ Emergency Medication must be with student at all times,or with an accompanying adult (requires 504)

Please Note: *The school nurse is not always available on field trips or during after school events/clubs/athletics. For this reason non-medical, unlicensed school staff members are trained to administer medication.*

Prescription medication or treatment <u>daily at school</u> for this condition: _____

Prescription medication or treatment daily <u>at home</u> 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, 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 school personnel that have direct contact with my child for the current school year. I understand that a trained 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 school 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 nurse 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 Madison County Board of Education Medication Policy and Procedures (09.2241) are readily available for me to read.

I hereby agree to release and hold Madison County Schools 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***

Discussed Bus Route Yes___NO___