Muscogee County School District
Student Health Services
SEIZURE STUDENT HEALTH CARE PLAN

Please bring or mail this health care plan to the school.
A new health care plan is required every school year.

Student: _____Date of Birth: _____School year: _____

School: _____Teacher: _____Grade/Team: _____

Emergency Contacts

Parent/Guardian/Contact	Relationship	Phone Number	Alternate Phone Number
Seizure Healthcare Provider:		**Phone Number:**	

SEIZURE HISTORY (Describe onset): _____

_____

_____

_____

_____

Has student ever been hospitalized for seizures?

- ☐ Yes
  If yes, length of hospitalization and complications: _____
- ☐ No

SEIZURE INFORMATION

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs: _____

_____

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EMERGENCY PLAN

Seizure emergency for this student is:

- ☐ Tonic-clonic seizure lasting longer than 5 minutes
- ☐ Difficulty breathing or change in color
- ☐ Cluster seizures (_____ number in _____minutes)
- ☐ Additional Chronic Health Condition: _____
- ☐ Other: _____

Emergency Actions (*Check all that apply*):

- ☐ Contact Clinic Staff
- ☐ Call 911 for transport to: _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications indicated below
- ☐ Notify seizure healthcare provider
- ☐ Other: _____

BASIC SEIZURE FIRST AID CARE:

- ☐ Stay calm and track time
- ☐ Keep student safe; protect head
- ☐ Do not restrain
- ☐ Do not put anything in mouth
- ☐ Document on *Student Seizure Log*

After seizure, does student need to leave classroom?

- ☐ Yes
  If yes, where: _____ Length of time: _____ Then: _____
- ☐ No

MEDICATIONS *(including daily and emergency medications)*

√ Given at school	Medication Name	Dosage(amount)/Time	When to use

Does student have a Vagal Nerve Stimulator?

- ☐ Yes
  If yes, describe magnet use: _____
- ☐ No

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Comments and Special Instructions (including school activities, sports, field trips, etc):

_____

_____

_____

_____

Physician's Authorization

My signature provides for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- If changes are indicated, I will provide new written authorized orders
- Dose/treatment changes may be relayed through parent/guardian.

Physician's Name: _____Phone Number: _____

Physician's Signature: _____ Date: _____

Parent/Guardian Consent for Management of Seizure Disorder at School

I _____(Parent/Guardian) hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Nurse and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's seizure disorder and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portable and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Muscogee County Schools. This authorization expires as of the last day of the school year.

I request designated school personnel to administer the medication and treatment orders as prescribed above. I agree to provide the necessary supplies and equipment and to notify the school nurse if there is a change in the student's health management or health care provider.

I understand that it is my responsibility to notify the bus driver, school administration, teacher, clinic worker and school nurse of any and all health conditions for my child.

Parent/Guardian's Signature: _____Date: _____