Fulton County Schools
Where Students Come First

Student Health Services

Seizure Action Health Care Plan

Student Name: _____ **Date of Birth**:_____

Teacher: _____ Grade: _____ School: _____

Seizure History (first and last seizure):_____

_____

_____

Description of Seizure: (what does it look like, how long does it last) _____

_____

_____

Rescue Medications (complete Seizure Treatment Order Form and Medication Authorization Form if medication is to be administered at school)

☐ Diastat dose:_____ ☐ Versed dose: _____ ☐Other: list with dose:_____

Will you be sending this medication to school? ☐ Yes ☐ No

PLEASE NOTE: If emergency medication is not available at school, 911 will be called for prolonged seizures

Daily Medications -Name, Dosage, Frequency (complete Medication Authorization Form if medication is to be administered at school): _____

_____

Action Plan for School: _____

_____

_____

I am the parent/guardian of _____ and request that the Seizure Health Care Plan be utilized during school hours.

School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. Completion of this Seizure Health Care Plan authorizes Student Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Health Care Provider Signature _____ Date: _____

Physician Name (print) _____ Phone # _____

Physician Address _____ Fax _____

Parent Signature _____ Date: _____

Parent Name (Print) _____Phone # _____

Received by _____Date:_____

Date Reviewed by Cluster Nurse/Special Education Nurse: _____

Cluster Nurse/Special Education Nurse Signature: _____