

SEIZURE

Emergency Care Plan

No Image Available

School:	Student Name:	DOB:							
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CONFIDENTIAL INFORMATION page 1 SHRED PRIOR TO DISCARD	Healthcare Provider's Name:	HCP Phone:	HCP Fax:						
	CONFIDENTIAL INFORMATION page 1 SHRED PRIOR TO DISCARD								

Name:			SEIZURE ECP	Age:	Gra	ad Year:	
			SEIZURE INFORM	MATION			
Seizure type	Typical length of seizure		Frequency	,	What the seizures look like in my child:		
Date of last seizure:							
Daily Medications:							-
Triggers							
Epilepsy Surgery (type, da	te_side_effects)						
Diet Therapy Ketogen	-	mic \Box M	lodified Atkins	ner (describe)			_
Seizure Device RNS Re			DBS Deep Brain Sti		Date Implanted	1	_
VNS Vagus Nerve Stimula		inidiacion	BBS Deep Brain Ser	inutation	Date implanted	<u>' </u>	
1. Keep magnet within 10-1		so it's acce	essible to activate the	VNS. Magnet	location		
2. Try to activate VNS at se							
3. Pass magnet over unit (le	eft shoulder/axilla) for a mini	mum of 2 - 3 seconds.	Possible	Side effects: voice cha	nge, cough, nausea, rapid	j
This initiates a dose of s				heart ra	ate		
4. Can be repeated a total	of 5 times. Wait	60 seconds	between each magnet	pass.			
Other Medical History							
* Individual health plan and rescue medication, if prescribed, must accompany student on any field trip or scheduled activity. * Keep health plan readily available for substitutes. * Notify parent/guardian of any concerns.							
		D/	ARENT/GUARDIAN IN	JEORMATION			
Danas (Consultant						Call Dhanas	
Parent/Guardian:			me Phone:	Work F		Cell Phone:	
Parent/Guardian:			me Phone:	Work F		Cell Phone:	
		1	ERGENCY CONTACT		I		
Name:		Phone:			Relationship:		
Name:		Phone:			Relationship:		
Name:		Phone:			Relationship:		
<u> </u>			ARDIAN CONSENT - You	•			
I request that authorized school personnel assist my child to take the medicine(s) described above. (If no box is checked, this is the default.) I, the student, am at least 18 years old and sign this form on my own behalf (RCW 26.28.015 or RCW 70.02.130). My signature indicates my permission for the exchange of information between school staff and the health care provider, and my understanding that the District and school staff will not incur any liability for any injury when the medication is administered in accordance with the health care provider's direction and Washington law. I understand that if this is a plan for a life threatening condition it can only be discontinued, in writing, by a health care provider. By signing, I am indicating agreement with this plan.							
Parent Signature:	Г	Parent/G	Guardian Signature on F	ile		Date:	
3	·		se and Administrator		s section		
School Nurse:		Jenoor Hul		Nurse's Signa		Date:	
Administrator:					or's Signature on File	Date:	
CONFIDENTIAL INFORMATION/ SHI	RED PRIOR TO DISCARI)	page 2 of 2				
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