Fayette County School Health Services

SEIZURE HEALTH CARE PLAN

Please bring or mail this health care plan to the school or send to the secure FAX at 770-719-2639

Student: ________________________________ **Date of Birth:**___________ **School Year:** __________

School: __________________________ **Homeroom Teacher:** ________________**Grade/Team:** _________

EMERGENCY CONTACTS

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

SEIZURE HISTORY:

Has student ever been hospitalized for seizures? ☐ **No** ☐ **Yes**   **If yes, length of hospitalization and complications:**   ____

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*
Seizure Triggers or warning signs:			

TREATMENT ORDER:

☐ Diazepam rectal gel _______mg rectally prn
☐ Diazepam intranasal ________mg one spray one nostril
☐ Midazolam intranasal ________mg one spray one nostril
☐ Other: ____

FOR:

☐ Seizures > ______minutes OR
☐ Cluster seizures ________or more seizures in ______hours

DEVICE ORDER:

☐ VNS (vagal nerve stimulator magnet) ____
☐ RNS (Responsive Neurostimulation) ____
☐ DBS (Deep brain stimulation) ____
☐ Other____

DAILY MEDICATIONS

Medication Name	*Dosage (amount)/Time*	*When To Use*	*Given at School*
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

► IMPORTANT – PLEASE COMPLETE REVERSE SIDE OR PAGE 2 AND SIGN◄

SPECIAL CONSIDERATIONS AND PRECAUTIONS (including school activities, sports and trips):

EMERGENCY PLAN:

Seizure emergency for this student is:

- ☐ Tonic-clonic seizure lasting longer than 5 minutes
- ☐ Cluster seizures (_______number in _______hours)
- ☐ Difficulty breathing or change in color
- ☐ 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 – if emergency medications are administered, 911 will be called and student will be transported to designated health care facility or released in the care of parent/guardian.
- ☐ Notify healthcare provider
- ☐ Other: ________________________________

Following a seizure: (Please check)

- ☐ Student may rest in school clinic if needed
- ☐ Parents/Caregiver should be notified immediately
- ☐ Student may return to class if baseline is achieved and student can safely participate in school activities.

BASIC SEIZURE FIRST AID CARE:

- √ Stay calm and track time
- √ Keep student safe; protect head
- √ Do not restrain
- √ Do not put anything in mouth
- √ Stay with student until fully conscious
- √ Documentation on *Student Seizure Record*

► *Physician's Signature*◄ ____ ***Date:*** ___________________

PRINT Physician's Name: _________________________________ **Telephone Number:** __________________

I, this child's parent/guardian, hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's seizures 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 Portability 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 Fayette County Schools. This authorization expires 1 year from date of signature.

► *Parent/Guardian's Signature*◄ ____ ***Date:*** ______________

Implemented: Aug 2001

Revised: Feb 2002; Aug 2003; Aug 2004; Sep 2005; Feb 2006; Apr 2012; Jun 2013, Jan 2016; May 2017; May 2020**,** March 2023, Sep 2024