Student Name _____ Grade_____
Date of Birth ____/____/____ Teacher_____

To be completed by PARENT / GUARDIAN:

USUAL Warning Sign(s) of students seizure activity include:_____
_____

Student usually has seizures (circle): daily a few times a week less than monthly

Physician providing care for seizures: Dr._____
Phone (____) ____-_____
Fax (____) ____-_____

Seizure Medication taken by student at home: _____Dose ____Freq_____
Will a dose of this medication be required during school hours? Yes No
Will Diastat be needed / provided for school? Yes No

Note: Parent must provide medication in original pharmacy-labeled container. Parent / Guardian is responsible for notifying school nurse for any change in student condition or change in treatment regimen. **Parent / Guardian signature serves as consent for information to be requested from or exchanged with the physician(s) listed above.**

Parent / Guardian signature: _____Date ___/___/___
Phone:_____

Seizure Management Plan

During seizure- Stay with the student
Time seizure length
Assist student to floor and pad under head
Position student on their side
Remove any hard / sharp objects from area
Do not attempt to restrain student
Do not put anything in to students mouth
Loosen any tight clothing-remove any glasses

After seizure- Allow student to rest
Remain with student until conscious, Re-orient
Document the seizure and specifics of episode
Notify parent(s)

*******Call 911 for seizure lasting >5 minutes or for ANY respiratory distress.**

FOR SCHOOL NURSE USE ONLY:
Plan reviewed by _____Date___/___/__
MD Orders Req'd:___/____/____ Rec'd___/___/___
_____Added to DD
_____Medical Alert notification to Grade level teachers, Cafeteria Mgr., PE Teacher, and specialty teachers
Medication Location : _____
Other:_____

TO BE COMPLETED BY PHYSICIAN:
(or attach copy of Physician Orders)

Diagnosis:_____

Medication to be administered while at school and instructions for calling 911: _____
_____
_____
_____
_____
_____

MD Signature_____
Date _____/____/_____