



KNOX COUNTY SCHOOLS

Health Services INDIVIDUALIZED SEIZURE PROTOCOL

Student's Name: _____ Date of Birth: _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

Seizure Information

Seizure Type: _____

MEDICATION

NAME OF MEDICATION: _____

REASON FOR MEDICATION: _____

ROUTE: _____ TIME: _____ FOR EPISODIC/EMERGENCY EVENTS ONLY

START DATE _____ END DATE _____

When to Notify EMS/911:

- Seizure with loss of consciousness longer than ____ minutes, not responding to rescue medications.
- Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med.
- Difficulty breathing after a seizure.
- Serious injury occurs during or after a seizure.
- Other _____

When to use Rescue Medications:

WHEN AND WHAT TO DO:

If seizure (cluster, # or length) _____

Name of Medication/Rx _____

Dose _____ Medication Route _____

Frequency _____

Start Date _____ End Date _____

If applicable, please check the appropriate box:

- does not have a ride limit or require a nurse during transportation.
- has a ride limit of _____ minutes and requires nursing during transportation.

Health Care Provider Group Name: _____

Address _____ Phone _____ Fax _____

Health Care Provider Signature: _____ Date _____

Parent / Signature: _____ Date _____

Phone Number _____ Relationship _____

TO BE COMPLETED BY SCHOOL PERSONNEL

Date Medication Received _____ Signature _____

Parent to sign in medication Enter in ASPEN Fax to Health Services Add to Procedures if needed Print MAR

This form is only good for the current school year.