



NOTE: Parents are to provide the physician’s medical management plan to the school *annually*. The medical orders, along with the health intake below, assist the school nurse in developing an Individual Healthcare Plan for the student.

If a seizure occurs at school, parents will be notified.

Student’s Name: _____ DOB: ___/___/___ Grade: _____ Today’s Date: ___/___/___

Parent/Guardian 1: _____ Contact Information: _____

Parent/Guardian 2: _____ Contact Information: _____

Name of physician treating student’s seizures: _____ Phone Number: _____

Health Insurance: Private Medicaid/KanCare Currently without insurance

Medical alert jewelry worn? Yes No IEP? Yes No Current 504 Plan? Yes No

Mode of transportation to and from school? _____

Does student participate in before or after school activities? Yes No

Description (diagnosis) of seizure type: _____

Other related medical conditions: _____

Age at onset of seizures? _____ When was the student’s last seizure? _____

Any known triggers (fatigue, heat, etc.)? _____

How does student act before a seizure (vision distorted, hearing or smell, etc.)? _____

What does student’s seizure look like (stares into space, body stiffens, loses bladder control, etc.)? _____

What emergency actions has the student previously needed (medication to stop seizure, ambulance, etc.)? _____

Frequency of seizures (number in a day, month)? _____

How long do the seizures typically last? _____ Single seizure or clusters? _____

Has student ever had a seizure that lasted longer than 5 minutes? Yes No

How does student act after a seizure (sleepy, cries, etc.)? _____

Describe the student’s understanding of their seizure disorder: None/Limited Basic Knowledgeable

What daily medications are prescribed for the student?

| Medication | Dosage | Time taken |
|------------|--------|------------|
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What **emergency/rescue** medications are prescribed for the student?

| Medication | Dosage | Administration (timing & method) | What to do after administration |
|------------|--------|-------------------------------------|------------------------------------|
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Does the student have a vagus nerve stimulator? Yes No

If yes, instructions for appropriate magnet use: _____

Special considerations and precautions: Check all that apply and describe any considerations or precautions that should be taken:

- General health _____
- P.E. & sports _____
- Learning _____
- Recess _____
- Behavior _____
- Bus transportation _____
- Mood/coping _____
- Other _____

Does student have family, peer, and community support systems? Yes No

Describe student’s response and current coping/adaptation to having seizures: _____

Parent/Guardian Signature: _____ Date: _____