

For _____ School Year (expires
at the end of August)

**SHORELINE SCHOOL DISTRICT
TREATMENT ORDER FORM: LIFE
THREATENING SEIZURES**

Must be accompanied by "Permission
to Administer Medication at School"
(PTAM) form when applicable

LICENSED HEALTH CARE PROVIDER* (LHP) ORDERS

Note: These orders *must* be renewed every year, before the beginning of each school year.

**Briarcrest Elementary School
2715 NE 158th St
Shoreline, WA 98155**

**ATTENTION: Susan Vieira, RN
Phone: 206-393-4176
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EMAIL: susan.vieira@ssd412.org**

Student Name: _____ Birth date _____ Grade/Grad Yr _____
LHP* Name _____ Phone _____ Fax _____

MEDICAL INFORMATION AND ORDERS – TO BE COMPLETED BY LHP*

****Please complete these treatment orders so we can better understand the student's needs****

STUDENT HEALTH HISTORY:

Student's seizure information (type, what they look like): _____

Early warning signs, if any: _____

Other related health history: _____

Daily medication: _____

In the event of a major disaster, the school may be responsible for the care of their students for as long as 72 hours. With this in mind, schools should be in possession of a 72-hour supply of this student's daily medication. Medication should be provided to the school by the parents, and a Permission To Administer Medication form (PTAM) should be completed with current medication orders for the school nurse.

Emergency medication: _____

If emergency medication is ordered for school, complete the attached PTAM Form with medication orders

TREATMENT PLAN:

Basic Seizure Safety: Stay calm and track duration of seizure, do not restrain, do not put anything in mouth, stay with student until fully awake.

For tonic-clonic (grand mal) seizure: Protect head, keep airway open, watch breathing, turn on side.

Additional treatment steps (include any emergency medication, treatments, when to seek additional care):

1. _____
2. _____
3. _____

Call 911 if: _____

CARE AFTER SEIZURE:

1. _____
2. _____

Licensed Health Care Provider* Signature

Date

Phone