

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.

Meridian Park Elementary School  
17077 Meridian Ave N Shoreline, WA  
98133

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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. \_\_\_\_\_

**Call 911 if:** \_\_\_\_\_

**CARE AFTER SEIZURE:**

1. \_\_\_\_\_
2. \_\_\_\_\_

\_\_\_\_\_  
**Licensed Health Care Provider\* Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Phone**

