



District Health Services

Seizure Action Health Care Plan

Student Name: _____ **Date of Birth:** _____

Teacher: _____ Grade: _____ School: _____

Seizure History (first and last seizure): _____

Description of Seizure: (what does it look like, how long does it last) _____

Rescue Medications (complete Seizure Treatment Order Form and Medication Authorization Form if medication is to be administered at school)

☐ Diastat dose: _____ ☐ Versed dose: _____ ☐ Valtoco dose: _____ ☐ Nayzilam dose: _____

When to administer: _____

☐ **Other Medications:** list with dosage: _____ **When to administer:** _____

☐ **VNS Magnet** (Vagus Nerve Stimulator): _____ **When to use:** _____

Will you be sending this medication to school? ☐ Yes ☐ No

PLEASE NOTE 911 will be called if seizure does not stop within _____ minutes of administering medication.

Daily Medications -Name, Dosage, Frequency (complete Medication Authorization Form if medication is to be administered at school): _____

Action Plan for School: _____

I am the parent/guardian of _____ and request that the Seizure Health Care Plan I am submitting be utilized for school purposes.

School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. The submission and completion of this Seizure Health Care Plan authorizes District Health Services to discuss the health care plan with the appropriate school staff and prescribing health care provider via email, fax, verbal, or written communication with the purpose of providing a safe environment for your child.

Physician/Health Care Provider Signature _____ Date: _____

Physician Name (print) _____ Phone # _____

Physician Address _____ Fax _____

Parent Signature _____ Date: _____

Parent Name (Print) _____ Phone # _____

Received/ Reviewed by Clinic Assistant _____ Date: _____

Date Reviewed by Cluster School Nurse/Special Education Nurse: _____

Cluster School Nurse/Special Education Nurse Signature: _____