RANKIN COUNTY SCHOOL DISTRICT SCHOOL SEIZURE HEALTH PLAN

DATE RECEIVED ____ / ____ / ____

TO BE COMPLETED BY PARENT OR GUARDIAN

Name ____ Age ____ Date of Birth ____

School ____ Teacher ____ Grade ____

Emergency Contact Name ____ Phone ____

TO BE COMPLETED BY PHYSICIAN OR LICENSED PRACTITIONER

Diagnosis ____ Diagnosis Date ____ Last Seizure / Episode Date ____

Type of seizure: ☐ Absence ☐ Simple / Complex Focal ☐ Tonic Clonic / Grand Mal

Brief description of seizure / episode:

List frequency and duration of seizures / episodes:

List all symptoms related to the seizures / episodes:

List any known triggers of seizures / episodes:

List any restrictions student must follow while at school:

List any medications:

Will the student need any medications administered at school? ☐ Yes ☐ No

If yes, please complete the Consent for Medication at School form and provide the medication to the school.

TO BE COMPLETED BY THE SCHOOL WITH PARENT/GUARDIAN

STUDENT/GUARDIAN WILL:

1. Avoid known seizure triggers.
2. Take all prescribed medications as prescribed and follow the plan of care.
3. Follow up with health care provider as appropriate.
4. Alert school staff immediately of any signs/symptoms of a seizure.

SCHOOL WILL:

1. Notify administration when the seizure begins, record the time and description of seizure activity.
2. Keep the student safe by moving any objects away that could harm them and ease the student to the floor wherever the seizure occurs.
3. Ensure the student is not held down or restricted in movement and nothing is placed in student's mouth.
4. Administer medications per Medication Consent Form approved by health care provider.
5. Call 911 if seizure activity lasts longer than 5 minutes or emergency medications are given.
6. Contact parent/guardian immediately.

Health Care Provider - Name (Print)	Health Care Provider - Signature
Parent/Guardian - Name (Print)	Parent/Guardian - Signature
School Representative - Name (Print)	School Representative - Signature