

Student's Name: _____

DOB: _____ Grade: _____ School Year: _____

Health Condition: Seizure – Emergency Care (Type of Seizure): _____)

Typical Seizure looks like: _____

PROCEDURE:

- | | |
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| <p>1. Child should never be left alone.</p> <ul style="list-style-type: none"> •Send someone to get another adult. •Contact parent immediately. •If unable to reach parent, contact emergency person identified on student information card. <p>2. Loosen all restrictive clothing around neck.</p> <ul style="list-style-type: none"> •Position student on their side, if possible, to prevent choking on saliva or vomit. •Do not insert anything in child's mouth including your fingers. •Place soft object under head. •Administer Diastat if prescribed, available and trained staff member is present. <p>3. Observe and record the seizure.</p> <ul style="list-style-type: none"> •Length of time seizure lasted (by the clock). | <p>4. Call ambulance if:</p> <ul style="list-style-type: none"> •Any movement of body parts, separate or all extremities involved (any jerking or continuous movement). •Any breathing problems or cyanosis (appears blue). •Any incontinence or stool or urine. •Diastat is given. •Seizure lasts longer than 5 minutes or seizure lasts less than 5 minutes and is followed by another seizure or multiple seizures. •Parent or emergency contact can not be reached. •Other _____ <p>5. Comfort and reassure child after seizure allowing them to rest</p> |
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Daily Seizure Medication: _____ Dosage _____ Frequency _____

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DOSAGE: EMERGENCY MEDICATION Name of medication: _____

Dose/Route _____

When to give medication (ex: seizure lasting more than 4 minutes) _____

Possible Side Effects: _____

Direct contact shall be made with the physician should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state): _____

Parent/Guardian Contact Name & Contact Number(s): _____

Medication Consent: I hereby give permission to designated trained school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed.
I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication.

I agree to notify the school at the termination of this request or when any change in the above orders is necessary.

____ Yes ____ No Authorization is hereby granted to release this information to appropriate school or classroom teachers.

Parent's Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____