



Seizure Health Plan

Student Name:	Graduation Year:
Parent/ Guardian Name(s):	Phone Number(s):
Physician's Name:	Phone Number:

Are seizures still an issue for your student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is your student on a daily home medication? Please Indicate:
Does your student have an emergency medication prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please have your physician fill out the physician medication orders on the next page.
Seizure triggers or warning signs:

Seizure Information				
Seizure Type	Date of Last Seizure	Length of Seizures	Frequency of Seizures	Description / Symptoms

Does student need to leave school after a seizure? (Please include criteria for when to stay or leave.)

Care Plan and Basic Seizure First Aid	When to Call 911
<ul style="list-style-type: none"> - Stay calm. Begin timing seizure. - Turn student onto their side, and place a soft item under the head. Keep airway clear. - Do not restrain student or put anything in their mouth. - Loosen tight items that are around their neck. - Remove other students from room, and move harmful objects away from student. - NEVER leave the student alone. - Call for Help. South Campus Health Room x4108, North Campus Health Room x4208 - Record seizure in log. Nurse will call parents. - If seizure is 5 minutes long, administer emergency medication if prescribed. - Let them rest after the seizure. It is normal to be tired and sleep after a seizure. - Activity Restrictions: <ul style="list-style-type: none"> ▪ Must have one on one supervision during swim activities. ▪ Restrict from activities which would place at a height or in hazardous situation, should a seizure occur. 	<ul style="list-style-type: none"> - ANYTIME an emergency medication is given. - When the seizure is lasting longer than 5 minutes. - Student has repeated seizures without recovering or waking up in between. - Serious injury occurs as a result of the seizure. - Seizure happens in water. - Student is diabetic or pregnant. - Do not worry if breathing stops for a few seconds during the seizure. Breathing should start as soon as the seizure is over. If student does not start breathing again, start CPR and call 911.
List any changes or additional information:	

Parent/ Guardian Care Plan and Medication Consent

- 1) I, hereby, give my permission for the school nurse, health room personnel, office staff or authorized school personnel to give the medication(s) listed below to my student according to the directions below should my student require it.
- 2) I, hereby, give the school nurse permission to contact the student's physician to discuss this action plan and/or medication.
- 3) I further agree to hold the Arrowhead School District, and the above-identified person(s) harmless in any or all claims arising from the administration of this medication.
- 4) I understand that this plan is valid for the school year it is provided during. I agree to provide a new health plan to the school nurse prior to the start of every school year. I agree to provide written notification to the school nurse at the termination of this request or when any changes are made in this care plan and/or medication.
- 5) I understand that 911 will be called when criteria in the "When to call 911" is met.
- 6) I understand that I must supply the emergency medication to school in the original pharmacy packaging/container. I will replace the supply if expired or it was used.
- 7) I agree to pick up the medication by the last day of school or it will be discarded. I understand that no medication will be stored over the summer.
- 8) I agree with the care plan listed above.

Parent/ Guardian Signature:

Date:

Physician Medication Orders

Name of Medication	Dose / Frequency	Route	When to Be Administered

Physician Authorization

Physician Name:

Physician Signature:

Date:

Health Office Personnel - Verify the Following:

- 1) Physician Medication Order is properly filled out and accompanies the medication. The form must be signed by both the physician and parent and the form matches the information on the medication bottle.
- 2) The medication is in its original packaging with pharmacy label, and is not expired.

FOR OFFICE USE ONLY:

DATE	AMOUNT OF MEDICATION DELIVERED/RETURNED	STAFF SIGNATURE	PARENT/GUARDIAN SIGNATURE OR SECOND VERIFIER	SKYWARD UPDATED