

Fayette County School Health Services

SEIZURE HEALTH CARE PLAN

Please bring or mail this health care plan to the school or send to the secure FAX at 770-460-3928.

Student: _____ Date of Birth: _____ School Year: 20__ - 20__

School: _____ Homeroom Teacher: _____ Grade/Team: _____

EMERGENCY CONTACTS

<i>Parent/Guardian/Contact</i>	<i>Relationship</i>	<i>Phone Number</i>	<i>Alternate Phone Number</i>
<i>Seizure Healthcare Provider:</i>		<i>Phone Number:</i>	

SEIZURE HISTORY:

<p>_____</p> <p>_____</p> <p>_____</p> <p>Has student ever been hospitalized for seizures? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, length of hospitalization and complications: _____</p>

SEIZURE INFORMATION:

<i>Seizure Type</i>	<i>Length</i>	<i>Frequency</i>	<i>Description</i>
<i>Seizure Triggers or warning signs:</i> _____			

EMERGENCY PLAN:

<p><u>Seizure emergency for this student is:</u></p> <p><input type="checkbox"/> Tonic-clonic seizure lasting longer than 5 minutes</p> <p><input type="checkbox"/> Difficulty breathing or change in color</p> <p><input type="checkbox"/> Cluster seizures (_____ number in _____ minutes)</p> <p><input type="checkbox"/> Additional Chronic Health Condition: _____</p> <p><input type="checkbox"/> Other: _____</p>
<p><u>Emergency Actions</u> (Check all that apply):</p> <p><input type="checkbox"/> Contact Clinic Staff</p> <p><input type="checkbox"/> Call 911 for transport to _____</p> <p><input type="checkbox"/> Notify parent or emergency contact</p> <p><input type="checkbox"/> Administer emergency medications indicated below</p> <p><input type="checkbox"/> Notify healthcare provider</p> <p><input type="checkbox"/> Other: _____</p>

IMPORTANT – PLEASE COMPLETE REVERSE SIDE AND SIGN

BASIC SEIZURE FIRST AID CARE:

<input type="checkbox"/> Stay calm and track time <input type="checkbox"/> Keep student safe; protect head <input type="checkbox"/> Do not restrain <input type="checkbox"/> Do not put anything in mouth <input type="checkbox"/> Stay with student until fully conscious <input type="checkbox"/> Documentation on <i>Student Seizure Record</i>
<p>After seizure, does student need to leave classroom? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, where: _____ Length of time: _____ Then, _____</p>

DAILY MEDICATIONS (including daily and emergency medications):

<input checked="" type="checkbox"/> Given at School	Medication Name	Dosage (amount)/Time	When To Use

<p>Does student have a Vagal Nerve Stimulator <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe magnet use: _____</p>
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SPECIAL CONSIDERATIONS AND PRECAUTIONS (including school activities, sports and trips):

Physician's Signature: _____ **Date:** _____

Physician's Name: _____ **Telephone Number:** _____

 I, this child's parent/guardian, hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's seizures and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Fayette County Schools. This authorization expires as of the last day of the school year.

Parent/Guardian's Signature: _____ **Date:** _____

Implemented: August 2001
 Revised: February 6, 2002; August 2003; August 2, 2004; September 9, 2005; February 20, 2006