



## 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: \_\_\_\_\_  Other: list with dose: \_\_\_\_\_

Will you be sending this medication to school?  Yes  No

**PLEASE NOTE: If emergency medication is not available at school, 911 will be called for prolonged seizures**

**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 be utilized during school hours.**

**School employees will not assume any liability for supervising or assisting in the utilization of this health care plan. 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 by \_\_\_\_\_ Date: \_\_\_\_\_

Date Reviewed by Cluster Nurse/Special Education Nurse: \_\_\_\_\_

Cluster Nurse/Special Education Nurse Signature: \_\_\_\_\_