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 770-719-2639.

Student: _____ Date of Birth:_____ School Year: _____

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

EMERGENCY CONTACTS

Parent/Guardian/Contact	*Relationship*	*Phone Number*	*Email*
Seizure Healthcare Provider:		***Phone Number:***	

SEIZURE HISTORY:

Has student ever been hospitalized for seizures? ☐ No ☐ Yes **If yes, length of hospitalization and complications: _____**

SEIZURE INFORMATION:

Seizure Type	*Length*	*Frequency*	*Description*
Seizure Triggers or warning signs:			

TREATMENT ORDER:

☐ DIASTAT® AcuDial™ (diazepam rectal gel) _____ mg rectally prn
☐ Versed (midazolam) intranasal _____ mg one spray one nostril
☐ Diazapam intranasal _____ mg one spray one nostril

☐ Seizures > _____ minutes OR
☐ Cluster seizures _____ or more seizures in _____ hours

DEVICE ORDER:

☐ VNS (vagal nerve stimulator magnet) _____
☐ RNS (Responsive Neurostimulation) _____
☐ DBS (Deep brain stimulation) _____
☐ Other_____

DAILY MEDICATIONS

Medication Name	*Dosage (amount)/Time*	*When To Use*	*Given at School*
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

►IMPORTANT – PLEASE COMPLETE REVERSE SIDE OR PAGE 2 AND SIGN◄

SPECIAL CONSIDERATIONS AND PRECAUTIONS (including school activities, sports and trips):

EMERGENCY PLAN:

Seizure emergency for this student is:

- ☐ Tonic-clonic seizure lasting longer than 5 minutes
- ☐ Cluster seizures (_____ number in _____ hours)
- ☐ Difficulty breathing or change in color
- ☐ Additional Chronic Health Condition:
- ☐ Other: _____

Emergency Actions *(Check all that apply):*

- ☐ Contact Clinic Staff
- ☐ Call 911 for transport to _____
- ☐ Notify parent or emergency contact
- ☐ Administer emergency medications – if emergency medications are administered, 911 will be called and student will be transported to designated health care facility or released in the care of parent/guardian.
- ☐ Notify healthcare provider
- ☐ Other: _____

Following a seizure: (Please check)

- ☐ Child may rest in nurses office if needed
- ☐ Parents/Caregiver should be notified immediately
- ☐ Child may return to class when returns to baseline and can safely participate in school activities.

BASIC SEIZURE FIRST AID CARE:

- ✓ Stay calm and track time
- ✓ Keep student safe; protect head
- ✓ Do not restrain
- ✓ Do not put anything in mouth
- ✓ Stay with student until fully conscious
- ✓ Documentation on *Student Seizure Record*

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

PRINT 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: Aug 2001

Revised: Feb 2002; Aug 2003; Aug 2004; Sep 2005; Feb 2006; Apr 2012; Jun, 2013, Jan 2016; May 24, 2017; May 12, 2020