

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

| <i>Parent/Guardian/Contact</i> | <i>Relationship</i> | <i>Phone Number</i> | <i>Email</i> |
|-------------------------------------|---------------------|---------------------|--------------|
| | | | |
| | | | |
| | | | |
| <i>Seizure Healthcare Provider:</i> | | <i>Phone:</i> | <i>Fax:</i> |

SEIZURE HISTORY:

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

SEIZURE INFORMATION:

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

TREATMENT ORDER:

- Diazepam rectal gel _____ mg rectally prn
- Diazepam intranasal _____ mg one spray one nostril
- Midazolam intranasal _____ mg one spray one nostril
- Other: _____

FOR:

- 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

| <i>Medication Name</i> | <i>Dosage (amount)/Time</i> | <i>When To Use</i> | <i>Given at School</i> |
|------------------------|-----------------------------|--------------------|--|
| | | | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | | <input type="checkbox"/> YES <input type="checkbox"/> 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)

- Student may rest in school clinic if needed
- Parents/Caregiver should be notified immediately
- Student may return to class if baseline is achieved and student 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 1 year from date of signature.

► **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 2017; May 2020, March 2023