# Muscogee County School District
## Student Health Services
### SEIZURE STUDENT HEALTH CARE PLAN

Please bring or mail this health care plan to the school.
**A new health care plan is required every school year.**

Student: ______________________ Date of Birth: ____________ School year: ________

School: ______________________ Teacher: ____________ Grade/Team: ____________

**Emergency Contacts**

| Parent/Guardian/Contact | Relationship | Phone Number | Alternate Phone Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| **Seizure Healthcare Provider:** | | **Phone Number:** | |

**SEIZURE HISTORY (Describe onset):** ______________________________

______________________________

______________________________

______________________________

______________________________

Has student ever been hospitalized for seizures?

- ☐ Yes
  If yes, length of hospitalization and complications: ______________________
- ☐ No

**SEIZURE INFORMATION**

| Seizure Type | Length | Frequency | Description |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Seizure triggers or warning signs:** ______________________________

______________________________

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## EMERGENCY PLAN

**Seizure emergency for this student is:**

- ☐ Tonic-clonic seizure lasting longer than 5 minutes
- ☐ Difficulty breathing or change in color
- ☐ Cluster seizures ( ______ number in _______minutes)
- ☐ 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 indicated below
- ☐ Notify seizure healthcare provider
- ☐ Other: ______________________________

## BASIC SEIZURE FIRST AID CARE:

- ☐ Stay calm and track time
- ☐ Keep student safe; protect head
- ☐ Do not restrain
- ☐ Do not put anything in mouth
- ☐ Document on *Student Seizure Log*

## After seizure, does student need to leave classroom?

- ☐ Yes
  If yes, where: ______________________ Length of time: _______ Then: ______________
- ☐ No

**MEDICATIONS** *(including daily and emergency medications)*

| √ Given at school | Medication Name | Dosage(amount)/Time | When to use |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Does student have a Vagal Nerve Stimulator?**

- ☐ Yes
  If yes, describe magnet use: ______________________________
- ☐ No

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**Comments and Special Instructions (including school activities, sports, field trips, etc):**

________________________________________________________________

________________________________________________________________

________________________________________________________________

________________________________________________________________

## Physician's Authorization

My signature provides for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- ☐ If changes are indicated, I will provide new written authorized orders
- ☐ Dose/treatment changes may be relayed through parent/guardian.

**Physician's Name:** ______________________________ **Phone Number:** ____________

**Physician's Signature:** ______________________________ **Date:** ____________

### Parent/Guardian Consent for Management of Seizure Disorder at School

I ______________________(Parent/Guardian) hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Nurse and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's seizure disorder 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 Portable 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 Muscogee County Schools. This authorization expires as of the last day of the school year.

I request designated school personnel to administer the medication and treatment orders as prescribed above. I agree to provide the necessary supplies and equipment and to notify the school nurse if there is a change in the student's health management or health care provider.

I understand that it is my responsibility to notify the bus driver, school administration, teacher, clinic worker and school nurse of any and all health conditions for my child.

**Parent/Guardian's Signature:** ______________________________ **Date:** ____________