SEIZURE
Health Management Plan
SCHOOL YEAR: _____

STUDENT NAME:	**DOB:**
SCHOOL:	**STUDENT ID:**

MOTHER:	**FATHER:**
HOME:	**HOME:**
WORK:	**WORK:**
CELL:	**CELL:**
Other Emergency Contact:	**Phone:**
Neurologist:	**Phone:** **Fax:**
Hospital Preference:	

SEIZURE Type: _____ **Length:** _____ **Frequency:** _____ **Date of Last Seizure:** _____

Description of seizure(s): _____
Seizure triggers/warning signs: _____

STUDENT HISTORY (including other medical conditions):

MEDICATIONS (include name, dose, frequency):

EMERGENCY MEDICATION:

Basic Seizure First Aid • Stay calm, observe, time • Keep student safe if wandering or confused • Stay with student until fully conscious • Record seizure activity • Contact parent	**Tonic-Clonic (generalized) Seizure First Aid** • Call for clinic worker and remove bystanders • Turn on side, protect head, remove potentially harmful objects, do not restrain, nothing in mouth • Keep airway open • Contact parent • Administer emergency medication as prescribed
Treatments, Considerations, Precautions:	**CALL 911 IF:** • Seizure lasts > 5 min or multiple seizures without recovery • Injury occurred or is suspected • Breathing does not return to normal • First-time seizure or student has diabetes • Emergency medication is administered

School Clinic: Copy of plan to be provided to Transportation Supervisor

PARENT SIGNATURE/DATE

COUNTY SCHOOL NURSE SIGNATURE/DATE

Information about students and family is strictly confidential.

Rev. 5/2022

Parent's Request and Authorization for Health Care Procedures

School Year: _____

STUDENT NAME: _____	DOB: _____
SCHOOL: _____	STUDENT ID: _____

We, the undersigned, who are the parents/guardians of _____, request that the following specialized health care procedure:

Diastat / Diazepam

Name of Procedure

be administered to our child.

We understand that the procedure will be done by designated school personnel under direct or indirect supervision. It is also understood that Gwinnett County school personnel are released from responsibility for any complications resulting from administration of this procedure.

We understand that whenever possible, the specialized health care procedure should be provided by the family before or after school hours.

We understand that we are also responsible for providing any equipment and supplies for the procedure.

_____ _____

Signature of Parent or Guardian Date

ADMINISTRATION OF MEDICATION REQUEST
(1 form per medication per student)

STUDENT NAME: _____ **Date of Birth:** _____
STUDENT NUMBER: _____ **TEACHER:** _____
SCHOOL: _____

For the safety of all students at our school, these guidelines should be followed:

1. Administration of prescription and over-the-counter medicine (even for a short period of time) is discouraged. Parents should check with their physician regarding the need for medications to be administered during school hours. Medications prescribed for three times daily often can be given before school, after school, and at bedtime. If you have any questions about this procedure, please call the school clinic.
2. All medications, both prescription and over-the-counter, must be accompanied by **this form and brought to the school clinic by an adult.**
3. All medications must be in the ORIGINAL CHILD PROOF CONTAINER. Prescription medications must be in the labeled prescription bottle. Pharmacists can give a duplicate labeled container with only the school dose. It is the responsibility of the parent/guardian to inform school of any changes and update medication forms. **Medications stored in envelopes, baggies, etc., will not be administered.**
   ALL MEDICATIONS NEED TO BE ADMINISTERED ACCORDING TO DIRECTIONS ON LABEL.
4. **Medications must be picked up at the end of the year, or the school will dispose of them.**

Name of Medication: _____ **Expiration Date:** _____

Reason Medication Given: _____

Amount to be Given: _____

Time(s) to be Given: _____

Possible Side Effects: _____

Special Instructions: _____

I, _____, grant permission for the principal or designee to assist in administration of medication listed above for my child, _____, while at school, or when on field trips.

I understand that the school personnel cannot assure that anything more than a reasonable effort will be made to assist the student and I further agree to waive any claims of liability that may rise against any school personnel relative to the administration of this medication to my child according to the instructions provided above.

Home: _____ Work: _____ Cell: _____

_____ _____
Signature of Parent Date

FOR CLINIC USE: ☐ Medication disposed of By _____ Date _____
☐ Medication picked up By _____ Date _____
(parent signature)

Rev. 5/2022