*Clinic Use* LOCATION OF EMERGENCY MEDICATION AT SCHOOL: _____

# SEIZURE
## Health Management Plan
**SCHOOL YEAR: _____**

| | |
|---|---|
| **STUDENT NAME:** | **DOB:** |
| **SCHOOL:** | **STUDENT ID:** |

| | |
|---|---|
| **Parent/Guardian:** | **Parent/Guardian:** |
| **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**<br>• Stay calm, observe, time<br>• Keep student safe if wandering or confused<br>• Stay with student until fully conscious<br>• Record seizure activity<br>• Contact parent | **Tonic-Clonic (generalized) Seizure First Aid**<br>• Call for clinic worker and remove bystanders<br>• Turn on side, protect head, remove potentially harmful objects, do not restrain, nothing in mouth<br>• Keep airway open<br>• Contact parent<br>• Administer emergency medication as prescribed |
| **Treatments, Considerations, Precautions:**<br>_____<br>_____<br>_____<br>_____ | **CALL 911 IF:**<br>• Seizure lasts > 5 min or multiple seizures without recovery<br>• Injury occurred or is suspected<br>• Breathing does not return to normal<br>• First-time seizure or student has diabetes<br>• 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. 3/2023

## 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

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

Rev. 5/2022