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 770-460-3928.

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: _____

_____

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 healthcare provider
☐ Other: _____

IMPORTANT – PLEASE COMPLETE REVERSE SIDE AND SIGN

BASIC SEIZURE FIRST AID CARE:

- Stay clam 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*

After seizure, does student need to leave classroom? No Yes
If yes, where: _____ _____ Length of time: _____ Then, _____

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

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

Does student have a Vagal Nerve Stimulator No Yes
If yes, describe magnet use: _____

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

_____
_____
_____
_____
_____

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

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: August 2001
Revised: February 6, 2002; August 2003; August 2, 2004; September 9, 2005; February 20, 2006; April 13, 2012