HARRISBURG SCHOOL DISTRICT 41-2

Seizure Disorder Health Care Plan

Student's Name: _____ Birth Date: ____/____/____ M ☐ F ☐

School: _____ Grade:_____ Teacher:_____ Rides Bus: Yes ☐ No ☐

Parent/Guardian Name: _____ Phone: _____

_____ Phone: _____

Emergency Contact: 1)_____ Phone: _____

2)_____ Phone: _____

Physician's Name: _____ Phone: _____

Neurologist's Name: _____ Phone: _____

Seizure Information to be completed by parent:

When was your child diagnosed with a seizure disorder? _____ When was your child's last seizure? _____

Seizure Type(s):

Seizure Type	*Length*	*Frequency*	*Description*

1. What might trigger a seizure in your child? _____
2. Are there any warnings and/or behavior changes before the seizure occurs? □ Yes □ No
   If yes, please explain:_____
3. Has there been any recent change in your child's seizure patterns? □ Yes □ No
   If yes, please explain: _____
4. How does your child react after a seizure is over? _____
5. Has your child ever required hospitalization due to a seizure? □ Yes □ No
   If yes, please explain: _____
6. How does illness affect your child's seizure control? _____
7. Does your child need protective equipment? □ Yes □ No
   If yes, please explain: _____
8. Does your child take any medication at home for their seizure disorder? □ Yes □ No
   If yes, please list:

MEDICATION	DOSE	TIME

TREATMENT DURING SCHOOL HOURS: (include daily and emergency medications)
**** To Be Completed by Physician****

Medication at School	Dosage and Time Given	Side Effects and Special Instructions

****All medication given at school will need a signed Medication Authorization Form****

Check all that apply and describe any precautions that should be taken:
**** To Be Completed by Physician****

☐ Physical Education: _____ ☐ Recess: _____

☐ Field Trips: _____ ☐ Bus Transportation: _____

☐ Other: _____

Seizure Emergency Protocol:	Basic First Aid:	Seizure Emergency:
• Contact school nurse/aide • Call 911 • Notify parent/guardian or emergency contact • Administer emergency medication • Other_____	• Stay calm • Track time • Keep student safe • Do not restrain • Do not put anything in mouth • Stay with child until fully conscious • Protect student's head • Keep airway open and watch breathing • Turn student on their side	• Convusive seizure lasting longer than 5 minutes • Student has repeated seizures without regaining consciousness • Student has a "first time" seizure • Student is injured or has diabetes • Student has breathing diffulties

Physician Signature _____ Date _____

***In Harrisburg, EMS will be activated by a call to 911 at which time we will state that we need transport to the hospital by Rural Metro. Harrisburg Volunteer Fire Department is typically first on the scene to further assist.**

*A **Medication and Treatment Authorization Form** must be completed and kept on file in the school health office. New Health Care Plans are completed yearly. Any updates throughout the school year should be submitted to the School Nurse.

* *This information will be come part of your child's confidential permanent record. If for any reason you do not wish to respond to part(s) of this form you are under no obligation to do so. Please understand that we are not responsible for injury or illness that may be a result of these omissions.*

By signing below I understand that I am giving my permission to share this information with school staff/trained personnel as needed with strict confidentiality maintained by all. I also give my permission for the school nurse/aide to contact the Primary Care Physician or Neurologist if further information or clarification is needed.

Parent/Guardian Signature:_____ Date:_____

School Nurse Signature:_____ Date:_____