SEIZURE DISORDER	MLS Grade/Teacher:	McKinney Middle Grade:	YSHS Grade:

Student Name: Physician Name (for seizure):

Parent Name: Physicain Address:

Contact Phone Number: Physician Phone Number:

*** School records indicate diagnosis of SEIZURES.

AGE Diagnosed: # seizures/past year: # ER visits: # hospitalizations:

*** Complete & return to school nurse within TWO WEEKS to ensure proper health care plan can be established.

*** Important to updated health information each new school year.

*** It is the responsibility of parent/guardian to provide necessary medication needed during the school day.

*** All students using prescribed inhalers must follow district guidelines for medication use

*** NOTIFY SCHOOL NURSE IMMEDIATELY IF CHANGES: phone number, medications, etc.

Symptoms usually OBSERVED with seizure:			
☐ Bluish color around mouth	☐ Loss of consciousness	☐ Staring/loss eye control	Other:
☐ Jerking body movements	☐ Unusual behavior	☐ Loss of bowel/bladder control	

Describe typical seizure:

Describe length of seizure:

Describe forewarning signs:

Describe frequency of seizures:

Describe behaviors/needs AFTER seizure:

Date LAST seizure:

*** Please describe any details of YOUR child's typical response to any/all symptoms (2):

Treatment plan for managing seizures:				
Taken @ school (1)		Medications:	Amount taken:	How often?
Y / N				
Y / N				
Y / N				

The usual procedure followed at school for seizures:

1. Observe seizure activity
2. If greater than 3 minutes or respiratory distress episodes, call 911
3. If less then 3 minutes and no respiratory distress, rest until recovered
4. Contact parent/guardian & school nurse
5. Return to classroom if stable

(1) The district medication policy requires parental/guardian and physician/primary care provider signatures on district forms for all medications administered during school activities. Forms are available on school website and/or school office.

(2) Any treatments and/or activity restrictions require written directions from the students' physician/primary care provider.

Parent/guardian signature: Date:

FOR SCHOOL NURSE ONLY:		
Nursing Dx:	☐ Stable history	☐ Diagnose form complete
	☐ Potential complications - injury	☐ NURSE review & initials
	☐ High risk - altered mental status, physical injury	☐ PRINCIPLE review
	☐ Other:	☐ HOMEROOM TEACHER review
Plan:	☐ No ongoing nrsg mgmt at school indicated	☐ MEDICATION in MEDICATION DRAWER
	☐ Standard procedure for seizure	☐ DASL updates
	☐ Standard medication procedure	☐ FIELD TRIP list updated
	☐ Individualized IEP (refer to DASL)	☐ ANNUAL staff training
	☐ Training	
	☐ Other:	☐ Nurse: