Little Chute Area School District
Health Services
SEIZURES

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STUDENT INFORMATION

STUDENTS NAME:	**DOB**:	**GRADE:**
SCHOOL ATTENDING:	**BUS STUDENT**: *YES* *NO*	

SEIZURE TYPES & TREATMENT

SEIZURE TYPE	*LENGTH*	*FREQUENCY*	*DESCRIPTION*

SEIZURE TRIGGERS OR WARNING SIGNS:

STUDENT'S RESPONSE AFTER A SEIZURE:

EMERGENCY RESPONSE:

A "SEIZURE EMERGENCY" FOR THIS STUDENT IS DEFINED AS:

_____

_____

_____

SEIZURE EMERGENCY PROTOCOL *(Check all that apply)*:

- ☐ Contact School Nurse or Main Office
- ☐ Notify Parent or Emergency Contact
- ☐ Notify Doctor
- ☐ Call 911 to transport to the hospital
- ☐ Administer emergency medications as indicated
- ☐ Other:_____

BASIC SEIZURE FIRST AID:

- Stay calm and track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

FOR TONIC-CLONIC SEIZURE:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A SEIZURE IS GENERALLY AN EMERGENCY WHEN:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

MEDICATION & AUTHORIZATION

TREATMENT PROTOCOL DURING SCHOOL HOURS *(Include daily & emergency medications)*

EMERGENCY OR DAILY MEDICATION	DOSAGE GIVEN	TIME OF DAY GIVEN	COMMON SIDE EFFECTS	SPECIAL INSTRUCTIONS

HAS EMERGENCY MEDICATION EVER BEEN ADMINISTERED? *YES NO If **yes**, date of last dose:*

STUDENT HAS A VAGUS NERVE STIMULATOR? *YES NO If **yes**, describe magnet use:*

PARENT/GUARDIAN MEDICATION CONSENT

I hereby give permission to designated trained school personnel to give medications to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication(s) administration and possible adverse effects of the medication. I further agree to hold the Little Chute Area School District and LCASD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school. I agree to notify the school at the termination of this request or when any changes in the above orders are necessary.

I understand, as the parent/guardian, I am responsible to assure that backup rescue medication is available to my child after school hours and traveling to/from and during school-sponsored events. Students' health information is shared via emails, copies of health plans and/or staff meetings with grade level teachers, coaches, bus companies, office staff and other pertinent LCASD staff.

By signing below you agree you have reviewed this health plan for your child and that the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.

EMERGENCY CONTACT:	**RELATIONSHIP TO STUDENT:**
(H) PHONE:	**(C) PHONE:**

PARENT/GUARDIAN SIGNATURE:	**DATE:**
PHYSICIANS NAME:	**PHONE:**
PHYSICIAN SIGNATURE:	**DATE:**

Principal's Initials: _____ Date: _____