

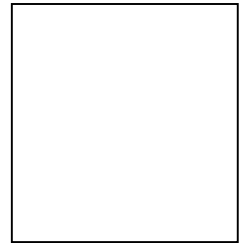
Little Chute School District

Health Services

Student's

Kara Kramer, RN, BSN, School Nurse 788-7605 x3302

Picture



325 Meulemans St Suite A, Little Chute, WI 54140

Fax (920)788- 7847

<b>Student's Name:</b>	<b>DOB:</b>	<b>Date:</b>
<b>School Attending:</b>	<b>Grade: Pre K</b>	<b>Bus Student:</b> Yes No
<b>Health Condition: Seizure – Emergency Care</b>		

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

<p><b><u>Basic Seizure First Aid</u></b></p> <ul style="list-style-type: none"> <li>Stay calm and track time</li> <li>Keep child safe</li> <li>Do not restrain</li> <li>Do not put anything in mouth</li> <li>Stay with child until fully conscious</li> <li>Record seizure in log</li> </ul> <p><b>For tonic-clonic seizure:</b></p> <ul style="list-style-type: none"> <li>Protect head</li> <li>Keep airway open/watch breathing</li> <li>Turn child on side</li> </ul>	<p><b><u>A Seizure is Generally Considered an Emergency When</u></b></p> <ul style="list-style-type: none"> <li>Convulsive (tonic-clonic) seizure lasts longer than 5 minutes</li> <li>Student has repeated seizures without regaining consciousness</li> <li>Student is injured or has diabetes</li> <li>Student has a first-time seizure</li> <li>Student has breathing difficulties</li> <li>Student has a seizure in water</li> </ul> <p style="text-align: center;"><b><u>Call ambulance if</u></b></p> <ul style="list-style-type: none"> <li>Diastat is given.</li> <li>Seizure lasts longer than 5 minutes or seizure lasts less than 5 minutes and is followed by another seizure.</li> <li>Parent or emergency contact can not be reached</li> </ul>
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A "seizure emergency" for this student is defined as:

Emergency Medication	Dosage	Common Side Effects & Special Instructions

Has Emergency Medication ever been administered? Yes \_\_\_\_\_ No \_\_\_\_\_ If YES, date of last dose:

**Medication Consent:** I hereby give permission to designated trained school personnel to give medication 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 administration and possible adverse effects of the medication. I further agree to hold the Little Chute School District, and the LCSD 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 change in the above orders is necessary.

I have reviewed the health plan for my child. (Please choose below)

\_\_\_\_\_ The plan is correct as written. \_\_\_\_\_ The plan is correct with the changes noted above.

Student health information/plans are shared via email, copies and/or staff meetings with grade level teachers, coaches, bus co. and office staff.

<b>Parent's Signature:</b>	<b>Date:</b>
<b>Physician's Signature:</b>	<b>Date:</b>