Deer Lakes School District
Individualized Health/Emergency Care Plan
Seizure Disorder

Student's Name ________________________ Grade ______ Age _______ HR Teacher _____________ School Year ___________

Please indicate TYPE OF SEIZURE ____

Describe what happens during the seizure(s): ____
____
____

What are some possible triggers of the seizure? ____

Are there any warnings and/or behavior changes before the seizure? ____

How long does it last? ____

Does student know if they are about to have a seizure? ____

What happens immediately after? ____

Student's reaction to seizure is ____and the best way to handle it is ____.

How long should student wait after seizure before returning to the regular school schedule? _________________________________

Average frequency of seizures: ___daily ___weekly ___ monthly ___yearly ___other: ___________________________

Usual time of day seizure(s) occur ____

How long has student had seizures? ____ Date of last seizure: _____________________

Is student taking medication for seizures? ___Yes ___No Name of medication: __________________________

Does your child wear a medic alert tag? ___Yes ___No

MANAGEMENT OF SEIZURE:

____
____
____

IF A CONVULSIVE OR GRAND MAL SEIZURE OCCURS:

- ***Remain calm, talk in a soothing manner; do not panic!***

1. Ease the student to a safe position and turn on side; clear away any objects from area
2. Loosen clothing at neck, remove glasses and *cushion* the head (with arms, lap, coat etc.).
3. DO NOT restrain or put anything in student's mouth. DO NOT try to stop purposeless behavior.
4. Designate someone to remove/redirect other students from area and notify nurse
5. Time the seizure and allow it to run its course.
6. Expect to see pale or bluish discoloration of the skin/lips. Expect to hear noisy breathing.
7. Stay with the student until they are fully awake and reoriented.

ACTIVATE EMS IF:

- **Seizure last more than 5 minutes**
- **Absence of breathing and/or pulse**
- **Student is having multiple seizures**
- **Student is injured or appears ill**

Other: ____
____
____

Notify Parent/Guardian

Check any special considerations related to your child's seizure disorder while at school and describe them:

___Educational concerns:

___Emotional/Behavioral Concerns

___Physical education precautions

___Recess Precautions

___Special considerations for field trips

___Special considerations for Bus ride to and from school

Is there anything else you would like to share that would better help us meet your childs needs?

My signature below indicates that I have completed the above information and agree with the recommended actions. I also authorize the release of this Individualized Health Care Plan to the employees of Deer Lakes School District.

→ ______________________________ ______________

Parent's Signature Date

→ ______________________________ ______________

Physician's Signature Date

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DEER LAKES SCHOOL DISTRICT
Medication Permission Form

Dear Parent and Physician:

Deer Lakes School District strongly recommends that student medications be administered at home, before or after school. If, under exceptional circumstances, it is absolutely necessary that the medication be giving during school hours, the following guidelines must apply:

1. **For the safety of your child, students are not permitted to transport or carry with them any medication (over the counter or prescription) at any time. Exceptions to this are outlined below.**
2. **No medications will be given back to the student to transport home.**
3. **Prescription medication must be in the original prescription labeled container (you can request a duplicate container from the pharmacist) accompanied by this completed form or a physician written order and a detailed note with parent/guardian signature.**
4. **Non-Prescription medication must be in the original container with student's name and accompanied by this form or a detailed note, indicating name of medication, dose, and time to give from parent/guardian. The nurse will request a physician's order to administer an over the counter medication.**
5. **Students who are authorized by a doctor to carry and/or self-administer a medication violate the Alcohol and Other Drugs policy IF he/she permits another student to take or ingest the medication.**
6. **Any medication not picked up by the last day of school will be disposed of in a non-recoverable manner.**

Student's Name____ __________
Last First Grade

I have read the above information and request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate herself/himself (as outlined below) also by me and my physician. We agree to hold the school, its offices, agents and employees harmless in administering the medication pursuant to the physician's written instructions. We further agree to notify you promptly when it is no longer necessary to administer this medication.

OVER THE COUNTER MEDICATIONS

1. **Medication** _____________________________ **Dose** _____________**Time**_____________ **For**___________________________
2. **Medication** _____________________________ **Dose** _____________**Time**_____________ **For**___________________________

▸▸**Parent/Guardian Signature:** ____________________________________**Date:** _______________

PRESCRIPTION MEDICATIONS **The PHYSICIAN must complete the following:**

Name of Medicine_________________________**Form**____________**Dose**________________
Time to be administered ______________________
Reason for Medication _______________________

Duration of time medication is required in school: ___________________________

If medicine is to be given "WHEN NEEDED" describe indications: _______________________________________
How soon can it be repeated? ________________________________
List significant side effects: ____
Length of time this treatment is recommended_______________________

PERMISSION TO CARRY AND/OR SELF MEDICATE

Is child authorized to medicate herself/himself? (Ex. Epi Pen or Inhaler) **Yes**____**No**_____
Student may carry inhaler, epipen (or other) in school or on Field Trips? **Yes**____ **No**_____

Any other necessary information: ____

Physicians Signature: _X____ **Date:** ________________

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