

Student Seizure Action Plan
Health Services Department
Holdrege Public Schools

Student Name: _____ ID #: _____ Grade: _____

INFORMATION FOR PARENTS AND GUARDIANS

If the condition named above affects your child, we request that you complete, sign, and return this form to the school health office.

- Sharing this information is important to keeping your child safe, and providing correct emergency response, at school.
- It is very important we have current emergency contact information for you.
- Written authorization from your child's physician is required for medically necessary cares at school (if any needed, including medications). New authorization is needed for each school year and when medical orders change.
- The school nurse may contact you or your child's physician if additional information or clarification is needed for cares at school.
- Information will be shared as appropriate with other school emergency personnel to benefit your child's safety and success.
- If you have questions, please contact the school nurse at your child's school.

School Nurse: Abbie Soneson School Phone: 995-8988 Date: _____

Parent/Guardian Name: _____ Phone (H): _____

Address: _____ Phone (W): _____

Parent/Guardian Name: _____ Phone (H): _____

Address: _____ Phone (W): _____

Emergency Phone Contact #1: _____
Name Relationship Phone

Emergency Phone Contact #1: _____
Name Relationship Phone

Physician Student Sees for Treatment of Seizures: _____ Phone: _____

Other Physicians: _____ Phone: _____

SEIZURES/HISTORY

Please describe your child's seizures:

Average Length of Seizure: _____ How often do the Seizures Occur? _____

Identify conditions that may trigger (cause) the seizure (e.g. noise, blinking lights, etc.):

Emergency room visits or hospitalization(s) for seizures within the last 3 years? ___No ___Yes When? _____

EMERGENCY PLANS FOR SCHOOL STAFF

1. Emergency action is necessary when the student has the following signs and symptoms:

a. seizure lasting longer than _____ minutes

b. or: _____

EMERGENCY MEDICATIONS OR TREATMENTS:

LOCATION OF EMERGENCY MEDICATIONS: _____ **HEALTH OFFICE** _____ **OTHER (describe)** _____

CONTACT PARENT/GUARDIAN WHEN: _____

STUDENT TO RETURN TO CLASSROOM WHEN: _____

DAILY MEDICATION PLAN

Name	Amount	When Given
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

COMMENTS/SPECIAL INSTRUCTIONS:

Parent/Guardian Signature: _____ Date: _____