Port Edwards Public Schools
801 Second Street
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# Seizure Care Plan

STUDENT:_____Grade/Teacher:_____DOB:_____

***PARENT/GUARDIAN TO COMPLETE:***

Description of seizure: _____

Triggers: _____

Frequency of seizures: _____ per _____. Last date of seizure was: _____

| Scheduled Medication Needed at School | Dose | Route | Time of Day | Possible Side Effects |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |

| Name of EMERGENCY Medication | Dose | Route | When to be Given | Side Effects |
|---|---|---|---|---|
| | | | | |

**AT THE END OF THE SCHOOL YEAR, PLEASE (check one):**

| Contact me to pick up remaining medication | Dispose of remaining medication | Send remaining medication home with my student |
|---|---|---|
| | | |

- I authorize that this medication be administered at school, potentially by non-medically trained personnel.
- I will supply medication in its original, updated, properly labeled container.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize the school to communicate with the provider regarding this medication/condition for which it is prescribed.
- I understand the parent/guardian/responsible adult should deliver all medication to the school.
- I understand that this order/ consent is in effect for the current school year (may include summer school).
- I consent that this treatment be provided during school hours, at after hours school sponsored events & on field trips.
- I consent to the release of the information contained in this Seizure Emergency Plan to staff members who may need to know this information to maintain my child's health and safety.
- I agree to hold the School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the information above.

**Provider Name: _____ Provider Phone Number: _____**
**Parent/guardian signature: _____ Date: _____**

***PROVIDER ORDER - Provider to complete:*** *The above medication is to be administered in accordance with the noted instructions. I agree to accept communication about student/medication/procedure and understand medication may be given by non-medically trained school personnel.*

Physician Name: _____Phone #: _____

Physician Signature: _____ Date: _____

*See next page*

## Seizure First Aid

- Stay calm and stay with the student
- Notify the parent/guardian/emergency contact
- Call 911
- Time the length of the seizure
- Don't hold the person down or try to stop their movements
- Clear the area around the person of anything they may sustain injury from
- Loosen ties or anything around the neck that may make breathing difficult
- Turn  onto one side
- Do not force the mouth open/ place anything in the mouth