NOTE: Parents are to provide the physician's medical management plan to the school ***annually.*** The medical orders, along with the health intake below, assist the school nurse in developing an Individual Healthcare Plan for the student.
If a seizure occurs at school, parents will be notified.

Student's Name: _____ **DOB:** ___/___/____ **Grade:** _____ **Today's Date:** ___/___/____

Parent/Guardian 1: _____ **Contact Information:** _____

Parent/Guardian 2: _____ **Contact Information:** _____

Name of physician treating student's seizures: _____ **Phone Number:** _____

Health Insurance: ☐ Private ☐ Medicaid/KanCare ☐ Currently without insurance

Medical alert jewelry worn? ☐ Yes ☐ No **IEP?** ☐ Yes ☐ No **Current 504 Plan?** ☐ Yes ☐ No

Mode of transportation to and from school? _____

Does student participate in before or after school activities? ☐ Yes ☐ No

Description (diagnosis) **of seizure type:** _____

Other related medical conditions: _____

Age at onset of seizures? _____ **When was the student's last seizure?** _____

Any known triggers (fatigue, heat, etc.)? _____

How does student act before a seizure (vision distorted, hearing or smell, etc.)?

_____

_____

What does student's seizure look like (stares into space, body stiffens, loses bladder control, etc.)

_____

_____

What emergency actions has the student previously needed (medication to stop seizure, ambulance, etc.)?

_____

Frequency of seizures (number in a day, month)? _____

How long do the seizures typically last? _____ **Single seizure or clusters?** _____

Has student ever had a seizure that lasted longer than 5 minutes? ☐ Yes ☐ No

How does student act after a seizure (sleepy, cries, etc.)? _____

_____

Describe the student's understanding of their seizure disorder: ☐ None/Limited ☐ Basic ☐ Knowledgeable

What **daily** medications are prescribed for the student?

Medication	**Dosage**	**Time taken**

What **emergency/rescue** medications are prescribed for the student?

Medication	**Dosage**	**Administration (timing & method)**	**What to do after administration**

Does the student have a vagus nerve stimulator? ☐ Yes ☐ No

If yes, instructions for appropriate magnet use: _____

_____

Special considerations and precautions: Check all that apply and describe any considerations or precautions that should be taken:

☐ General health _____

☐ P.E. & sports _____

☐ Learning _____

☐ Recess _____

☐ Behavior _____

☐ Bus transportation _____

☐ Mood/coping _____

☐ Other _____

Does student have family, peer, and community support systems? ☐ Yes ☐ No

Describe student's response and current coping/adaptation to having seizures: _____

_____

Parent/Guardian Signature: _____ **Date:** _____