Mecklenburg County Health Department School Health Program

	Year: _	Grade:	Date of Birth:	Allergies:
Homeroom T	eacher:	Room	n: Student ID	#:
Parent/Guard	ian:		Ph. (H):	
Address:			Ph. (W):	
Parent/Guard	ian:		Ph. (H):	
Address:			Ph. (W):	
Emergency P	hone Contact #1:			_
	Name		Relationship	Phone
Emergency P	hone Contact #2:			_
	Name		Relationship	Phone
-	ating student for seizure disorder:			
-	ian:			
Preferred Hos	spital:			
EMERG	ENCY PLAN (Fil	l in blanks cross out and i	nitial any steps not needed for t	his student)
	action is necessary when th			
Linergency	action is necessary when th	e student has the fo	nowing symptoms	
	during seizure episode.	d after seizure. Note	e duration of seizure and	d type of body movement
2.3.	•	ss of consciousness	occurs. Remove glasse	s if wearing, loosen clothi
2.3.4.	during seizure episode. Assist to lying position if lo around neck. Turn on side as soon as poss	ss of consciousness sible.	occurs. Remove glasse	s if wearing, loosen clothing
2.3.4.5.	during seizure episode. Assist to lying position if lo around neck. Turn on side as soon as poss Clear area around child to pa	ss of consciousness sible. revent injury; remover the revent of the reve	occurs. Remove glasse ve other students from a ACE ANYTHING IN	s if wearing, loosen clothirea if possible.
 3. 4. 6. 7. 	during seizure episode. Assist to lying position if lo around neck. Turn on side as soon as poss Clear area around child to propose to the property of the	ss of consciousness sible. revent injury; remove the consciousness of con	occurs. Remove glasse we other students from a ACE ANYTHING IN on if breathing does not a the student has one seizer physical/respiratory di	s if wearing, loosen clothing rea if possible. MOUTH. resume spontaneously. are after another without stress. If 911 is called,
 3. 4. 6. 7. 	during seizure episode. Assist to lying position if lo around neck. Turn on side as soon as possed clear area around child to propose to be a soon as possed to be soon as possed to be a soon as possed to be a soon as possed to	sible. revent injury; remove VEMENT OR PL n artificial respiration ger than 5 minutes, to significant injury of	occurs. Remove glasse we other students from a ACE ANYTHING IN on if breathing does not a the student has one seizer physical/respiratory di	s if wearing, loosen clothic rea if possible. MOUTH. resume spontaneously. are after another without stress. If 911 is called, Hospital.
 3. 4. 6. 7. 	during seizure episode. Assist to lying position if lo around neck. Turn on side as soon as possed. Clear area around child to proposed	sible. revent injury; remove VEMENT OR PL n artificial respiration ger than 5 minutes, to significant injury of	occurs. Remove glasse we other students from a ACE ANYTHING IN on if breathing does not a the student has one seizer physical/respiratory di	s if wearing, loosen clothing rea if possible. MOUTH. resume spontaneously. are after another without stress. If 911 is called, Hospital.
 3. 4. 5. 7. 8. 9. 	during seizure episode. Assist to lying position if lo around neck. Turn on side as soon as possed. Clear area around child to proposed	sible. PVEMENT OR PL In artificial respiration ger than 5 minutes, to significant injury of the child to rest and also	occurs. Remove glasse we other students from a ACE ANYTHING IN on if breathing does not a the student has one seize or physical/respiratory di	s if wearing, loosen clothic rea if possible. MOUTH. resume spontaneously. are after another without stress. If 911 is called, Hospital. dian.

Daily Seizure Management Plan:

1.	What type of seizures does your child have and how often do they occur?			
	Date of last seizure:			
2.	Describe your child's symptoms during and after a seizure episode.			
3.	Does your child have an aura or warning of a seizure coming? Yes No			
	Is he/she able to notify anyone that a seizure is coming? Yes No			
4.	Name medications taken routinely. How often and how much?			
	At home:			
	At school:			
	Does your child experience any side effects to these medications? Please list:			
	Are there any sports/activities in which your child CANNOT participate?			
	NOTE: If medications are to be taken at school, a Medication Authorization form must be completed by t and physician and kept at the school.			
Parent/Guardian Signature: Date:				
School Nu	rse Signature: Date:			

This information will be shared with appropriate school staff unless you state otherwise.

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