Seizure Care Information from Parent/Guardian

Your school nurse will use the following information to plan for safe care of your child should a seizure occur at school. Parents/guardians are notified and EMS (911) called if a student has difficulty breathing, the seizure lasts longer than 5 minutes, if more than one seizure occurs, or if a long period of time has occurred since the last seizure.

Student Name _____ Birth Date _____ Grade _____

Parents/Guardians _____ Home # _____ Alternate # _____

Emergency contacts _____ Home # _____ Alternate # _____

Physician who cares for your child's seizure disorder _____ Phone # _____

Last date your child was seen by this doctor? _____Next appt _____ Age diagnosed _____

List type(s) of seizure(s) your child has (grand mal, petit mal, partial/complex, etc.) _____
_____

What usually makes the siezure(s) start? Describe how your child behaves when a seizure starts.

_____
_____
_____

How long do the seizures last? _____

How often does your child have a seizure? _____

Medications or procedures given at HOME: _____

SCHOOL: _____ Diastat? ◯ Yes ◉ No

Vagal Nerve Stimulator (VNS)? ◯ Yes ◯ No

<u>Authorization for Release of Medical Information</u>:

I hereby authorize _____ to furnish medical information regarding
(Clinic/Provider)

my child _____ to the School Nurse at _____.
Student's name School

_____ _____ _____
Parent/Guardian's Signature Print name Date

I give permission for the School Nurse to communicate with my child's doctor concerning their medical condition.

_____ _____ _____
Parent/Guardian's Signature Print name Date