Northampton Area School District

EMERGENCY HEALTH CARE PLAN: SEIZURE DISORDER

SCHOOL ______________________

Student: ____________________________ Grade: _______________ Date: __________

Parent/Guardian________________________ **Phone:** ____________ **Phone:** ___________

Parent/Guardian________________________ **Phone:** ____________ **Phone:** ___________

Other Emergency Contact:____________________________________ **Phone:**___________

Physician:____ **Phone:**___________

Medical Condition: Seizure Disorder

Type of Seizure: ____

Frequency of Seizures:____________________________________

Duration of Seizure:_____________________________________

In the Event of a Seizure during the school day, follow the steps below:

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Is Medication kept at school? _____**Yes (Name of med:**_________________________) ______**No**

If Yes, where is medication kept? __________**Main Office** ________**Health Room** ________**Other**

Directions for medication administration: ____

Special Instructions (for field trips, etc):

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****Attached observation form should be completed by school faculty member who was with student at time of seizure.**

I give my permission for this information to be shared with adults at NASD on a need to know basis. This health care plan will be in effect for the current school year. I understand that it is my responsibility to notify the Health Services office whenever there is a change in my child's health status or care.

_____________________________ ___________ ______________________________

Parent Signature Date Parent Signature

_____________________________, School Nurse