Freedom Area School District
Health Services
Amie Kazik RN, BSN, District Nurse
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Student Name:	**DOB:**	Date:
School:	Grade:	Bus Student: Yes No

Co-Curriculars:

Health Condition: Seizure- Emergency Care

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic Seizure First Aid

- Stay Calm and track time
- Keep Child Safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record in seizure log

For Tonic-Clonic Seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

A Seizure is generally considered an emergency when

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing with difficulties
- Student has a seizure in water

Call Ambulance If

- Emergency medication is administered
- Seizure lasts longer than 5 minutes or seizure lasts less than 5 minutes AND is followed by another seizure
- Patient or emergency contact can not be reached

Emergency Medication	Dosage	Side Effects & Special Instructions

Has Emergency Medication ever been administered? Yes ______ No ______ If YES, date of last dose:

Medication Consent: I hereby give permission to designated trained school personnel to give medications to my student during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form. I also hereby agree to give my permission to the school nurse and/or school personnel to contact the child's physician if needed. I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medications administration and possible adverse effects of the medication. I further agree to hold Freedom Area School District employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication. I agree to notify the school at the termination of this request or when any changes in the above orders are necessary.

Students health information is shared via emails, copies of health plans and/or staff meetings with grade level teachers, coaches, bus companies, office staff, and other pertinent FASD staff.

By signing you agree you have reviewed this health plan for your student and the health plan is correct and/or you have made the appropriate changes on this form to make the plan correct.

Parent's signature:	Date:
Physician's signature:	Date: