McPherson County Schools – Health Services

Smoky Valley USD 400 McPherson USD 418 Canton/Galva USD 419 Moundridge USD 423 Inman USD 448

SEIZURE HISTORY FORM AND HEALTH CARE PLAN

Student Name:	Date of Birth:
History Taken by:	Date:
Parent/Guardian:	
Home Phone:	Work Phone:
Alternate Contact:	Phone:
Primary Health Care Provider:	Phone: Address:

History (include any previous medication taken for seizures)**:**	
Last major seizure:	
Frequency of major seizures:	
Date of last EEG and other lab tests:	
Circle symptoms/characteristics below that apply to your child, use the section to the right for additional comments	*(additional comments below)*
Seizures are provoked by (flashing lights, not sleeping, not eating, stress, fever, allergies, pain):	
Student's Warning Signs (rising sensation, slurred speech, shortness of breath, bad smell, confusion, palpitation, fear, tremor, sweating, flashing light, dizziness, scream, tunnel vision, tingling, pain, twitching):	
Seizure Type (Petit Mal/Absence, Tonic Clonic/Grand Mal, Other)**:**	
Student's Seizures usually look like (shaking, loss of consciousness, turning to one side, sweating, staring, raising arm, screaming, confusion, foaming at mouth, head banging, can hear but can't respond, noisy breathing, biting tongue, loss of vision, rigidity, wetting pants, picking at clothes, turning pale, smacking lips, blinking eyes, turning red, flailing arms):	
After seizure student looks like (confused, agitated, weak, numb, blurred vision, headache, sleepy, can't talk right, irritable, depressed, angry, euphoric):	

Other health concerns (other diagnoses, allergies):	
Medications:	**Dose/Time:** **Side Effects:**
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Special Considerations and Precautions (physical education/sports, recess, field trips, bus transportation, behavior, learning):

(continue on reverse side)

Seizure Action Plan (To Be Completed By Physician)

Student:_____Diagnosis:_____Teacher/Grade:_____

Medication #1: _____Dosage: _____Time:_____Route: _____

Medication #2: _____Dosage: _____Time:_____Route: _____

Absence/Complex Partial Seizure. These are characterized by staring or purposeless activity. Student may seem unaware of surroundings and unresponsive to verbal commands. Other signs include: drooling, mumbling, picking at own or others clothing, running, struggling, especially if restrained.	After seizure there is often no memory of actions. **Allow student to rest 30 minutes or until alert enough to get up. Report seizure to parent or nurse.**
Tonic Clonic/Grand Mal Seizure (convulsive seizure): These are characterized by sudden cry, loss of consciousness, fall, rigidity, followed by muscle jerks, frothy saliva or lips, shallow breathing or breathing may stop for a short time, bluish skin, possible loss of bladder or bowel control, usually lasts 2-3 minutes. Normal breathing then starts again. There may be some confusion and/or extreme tiredness and may sleep until returns to full consciousness. May be mistaken for heart attack, stroke, or unknown life threatening emergency.	* Note time – say it out loud * Clear all other students from room * Call office for medication and assistance if needed – do not leave the student alone *Turn to side to avoid choking *Protect student from injury – clear desks or tables. *Do not restrain *Do not put anything into the mouth *Reassure student when conscious *Do not offer food or water *CPR if breathing is absent *Record observations before, during and after the seizure. *Administer Diastat/_____ for seizure lasting longer than _____minutes (**see attached sheet for instructions**) **Call 911 for:** • A seizure lasting longer than _____minutes • Any signs of respiratory distress (stops breathing or turns dusky/blue) • Other_____
Additional actions after seizure:	

Licensed Health Care Provider Signature _____Date _____
(M.D., D.O., D.D.S., A.R.N.P., or P.A.)

PARENT / GUARDIAN PERMISSION TO ADMINISTER MEDICATION / INFORMATION EXCHANGE

I hereby give my permission for my child to take the above prescribed medication at school as ordered. I understand that it is my responsibility to furnish the medication in the original container appropriately labeled by the pharmacy / manufacturer or physician stating the name of the medication, the dosage, time to be given, and number of days to be administered at school. Any school employee who administers any medication in accordance with written instructions from the prescribing health care provider shall not be liable for damages as a result of any adverse drug reaction suffered by the student. If the student self-administers the medication, I acknowledge that the above named student has been instructed on self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication. I understand the school policy regarding medication.

I also give permission for the exchange of confidential health information between the school nurse, other representatives of my child's school, and the prescribing health care provider/pharmacy in the event a question or concern arises. I may revoke this consent to release information in writing and dated at any time except to the extent that action has been taken or information disclosed pursuant to signed consent. This consent shall remain in effect for a period of one year from signature date. To revoke this authorization, I should contact: my child's school or McPherson County Special Education Cooperative, 514 N Main, McPherson, KS 67460. Once information is disclosed, it may no longer be subject to HIPAA protections.

EMERGENCY MEDICATION ONLY: My child may carry inhaler / emergency medication (asthma, severe allergic reaction, diabetes management) with him/her. He / She has been instructed in the proper use and storage of this medication and has the ability to use the medication as prescribed.

Parent/Guardian Signature_____Date_____

Printed Name of Parent/Guardian_____