

Health and Wellness Services

1200 South Barr Street • Fort Wayne, IN 46802 • Phone: 260.467.1080 • Fax: 260.467.2862

SEIZURE Parent and Physician Information 2019-20

PARENT INFORMATION

Student _____ Grade _____ D.O.B. _____ Room _____
 Parent/Legal Guardian Name: _____ Daytime Phone: _____ Cell: _____
 Emergency Phone Contact #1: _____ Relationship: _____ Daytime Phone: _____ Cell: _____
 Emergency Phone Contact #2: _____ Relationship: _____ Daytime Phone: _____ Cell: _____
 Family Doctor: _____ Telephone: _____ Neurologist: _____ Telephone: _____

Hospital Preference Lutheran (W. Jefferson) Lutheran (Dupont) Parkview (North) Parkview (Randallia) Saint Joseph

Identify the things that may trigger a seizure in your child -Check all that apply

Exercise Stress Fatigue Heat Other _____

Seizure History

Age when seizures began _____ Date of last doctor's appointment for seizures _____ Date of last seizure _____

Type of Seizures

Absence Simple partial Complex partial Generalized tonic-colonic Pseudo Seizure Other _____

Aura (Prior to Seizure) ___ Yes ___ No

Describe

Emergency Care

School staff will call 911 for the following circumstances: absences of breathing or pulse, seizure lasting longer than 5 minutes or a seizure that persists beyond 5 minutes after special medications or procedures have been started, two or more seizures without a period of consciousness >5 minutes between, continued pale or bluish skin lips, or noisy breathing after the seizure stops. Other _____

Daily Medications taken to control Seizures

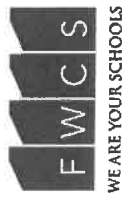
Medication Name	Amount	When Used (Time)	When Used (Time)	Has your child ever received this medication?
1.				<input type="checkbox"/> yes <input type="checkbox"/> no
2.				<input type="checkbox"/> yes <input type="checkbox"/> no
Emergency Medications or Measures Note: these will need physician authorization for use at school				
Medication Name	Amount	When Used (Time)	When Used (Time)	Has your child ever received this medication?
1.				<input type="checkbox"/> yes <input type="checkbox"/> no
2.				<input type="checkbox"/> yes <input type="checkbox"/> no

Note: If school nurse is not available Diastat may be administered by trained unlicensed staff in the school setting. Diastat/ Versed cannot be administered on a school bus. Bus drivers will dispatch EMS for care. If the first dose of emergency medication is given at school, school staff will call 911 after it is given. Versed may ONLY be administered by a school nurse, and school staff must call 911 for immediate attention with seizure activity if nurse is unavailable.

I agree that this information (plan) may be shared with the appropriate staff members, who work with the student, on a need to know basis. I hereby release Fort Wayne Community School District and any of its agents, employees, administrators, from any liability for any injury or harm which is suffered by my child as a result of our District's agreement to honor the above request. I agree to allow the school nurse to contact my physician about my child's treatment plan for school. I agree to keep the school nurse updated in writing about my child's health, and contact the school nurse in writing if any changes are made in the plan.

Parent Signature _____

Date _____



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PHYSICIAN INFORMATION

This section is only to be filled out by the health care provider and is only necessary for the special circumstances listed below.

Student _____ DOB _____
Seizure Care _____

Student may remain at school after a seizure if the seizure is < _____ and recovery time is < _____

Use Diastat®(diazepam rectal gel) _____ mg rectally PRN for: Use Versed _____ mg nasally PRN for:
 Seizure greater than _____ minutes AND/ OR Seizure greater than _____ minutes AND/ OR
 for _____ or more seizures in _____ hours. for _____ or more seizures in _____ hours.

Note: If school nurse is not available Diastat MAY be administered by trained unlicensed staff in the school setting. Diastat/Versed cannot be administered on a school bus. Bus drivers will dispatch EMS for care. If the first dose of emergency medication is given at school, school staff will call 911 after it is given. Versed may ONLY be administered by a school nurse, and school staff must call 911 for immediate attention with seizure activity if nurse is unavailable.

Use Vagal Nerve Stimulator (VNS) Magnet

Position of VNS (Please Indicate)

1. Assist student to a safe position with head to the side (to keep airway open)
2. Locate the implanted generator in the _____ chest.
3. Swipe the magnet over the implant, moving from **bottom to top**, to the count of 1-2-3. (This can be done over clothing)
4. Swipe again if the seizure continues for more than one minute. Continue to swipe once each minute until seizure activity ceases.

Other _____

Activity Restrictions

Helmet needed Recess Gym/Sports Swimming Field Trips Other _____

Details of restrictions _____

CALL 911 if

- Seizure does not stop by itself within _____ minutes.
- Two or more seizures **without** a period of consciousness between, which last 5 minutes or greater.
- Continued unusually pale or bluish skin/lips or noisy breathing after the seizure has stopped.
- Seizure does not stop with VNS within _____ minutes.
- Seizure does not stop within _____ minutes of giving Diastat or Versed
- Child does not start waking up within _____ minutes after seizure is over (**no Diastat given**).
- Child does not start waking up within _____ minutes after seizure is over (**AFTER** Diastat is given).
- Immediately following intranasal versed administration.

Physician Signature _____ Date _____