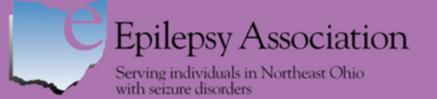
This student is being t below should assist yo Student's Name Date of Birth	ou if a seizure occurs			Photo of Student Here
Parent/Guardian: Phone Cell			Significant Mec	lical History
Other Emergency Co Phone Cell				
Treating Physicians: Address Phone				
	SEIZURE IN	IFORM	ATION	
Focal Onset \bigcirc	Generalized Ons	set 🔿	Mixed 🔘 U	Inknown Onset \bigcirc
Seizure Type	Length of Time		Frequency	Description
Seizure Triggers			Student's Resp	onse After Seizure
Warning Signs				



EMERGENCY RESPONSE

A "seizure emergency" for this student is defined as:

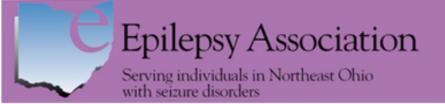
SEIZURE ACTION PROTOCOL:

Actions to take in the case of a seizure at school **Indicate the numerical order of steps in plan**

 Contact school nurse or other trained staff
Notify Doctor Other

TREATMENT PROTOCOL DURING SCHOOL HOURS

		COMMON SIDE EFFECTS
MEDICATION	DOSAGE / HOW OFTEN	& SPECIAL INSTRUCTIONS



Additional Instructions:

List other medications taken at home:

Describe any special considerations and precautions (regarding school activities, sports, trips, etc).

Does student have a VAGUS NERVE STIMULATOR (VNS)? OYES ONO

If YES, describe magnet use:

Physician Signature	Date
Parent/ Guardian Signature	Date



with seizure disorders

General Information

BASIC SEIZURE FIRST AID

- Stay calm and track time
- Do not restrain
- Do not put anything in mouth
- Stay with student until fully conscious
- Record seizure on plan

For Tonic-clonic (grand mal) seizure:

- Protect Head
- Keep airway open/watch breathing
- Turn student on side

A SEIZURE IS GENERALLY CONSIDERED AN EMERGENCY WHEN:

- Convulsive seizure lasts longer than five minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first time seizure
- Student has breathing difficulties
- Student has a seizure in the water

Serving individuals in Northeast Ohio

with seizure disorders

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the undersigned, authorize ______ (Disclosing Institution) and its employees to release information from my medical records as describes above to the school nurse. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand that I have a right to revoke t his authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department of the treating physician. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one (1) year from date of signature.

I understand that treatment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

As a professional courtesy, no cost is assessed for information released directly to your health care provider.

Revocation of this release still entitles me to all other rights of a student within the ______ (School District).

Parent/ Guardian Signature	Date
Student Signature (If Applicable)	Date

Description of Legal Representative's Authority to Act on Behalf of Student (if applicable):

