MADISON CONSOLIDATED SCHOOL CORPORATION
STUDENT SEIZURE PLAN OF CARE
Order and Emergency Seizure Plan
Fax: 812-274-8708

(To be completed and signed by the physician)

Student Name ______________________ **Date of Birth** ________________

School ______________________ **Grade** ________ **Teacher** _______________

Scheduled Bus _______ **Bus Driver** ______________ **Bus Aide** ______________

Student Age __________ **Student Weight** ________________

SEIZURE TYPE: ________________________________ **DESCRIBE:** ______________________

____

TREATMENT:

- **DIASTAT (diazepam rectal gel)** ____________________mg rectally prn for:
  Seizure > ___________minutes OR for __________or more seizures in ________hours.
  Other:____
- **Use VNS (vagal nerve stimulator) magnet**____
- **OTHER** ____
- **CALL 911 if**
  - ➢ Seizure does not stop by itself or with VNS within _______ minutes
  - ➢ Seizure does not stop within _______ minutes of giving DIASTAT
  - ➢ Student does not start waking up within _______ minutes after seizure is over (no DIASTAT given)
  - ➢ Student does not start waking up within _______ minutes after seizure is over (after DIASTAT given)
- **Following a seizure**
  - ✓ ______ Student should rest in nurse's office
  - ✓ ______ Parents/caregiver should be notified immediately
  - ✓ ______ Student may return to class
  - ✓ ______ Parents/caregiver should receive a note/copy of the seizure record sent home with the child

Physician Name (Printed) ____

Physician Phone Number ______________________________ Fax __________________________

Physician Signature ____ Date ____________

PLEASE HAVE THIS FORM FILLED OUT BY YOUR PHYSICIAN AND RETURNED TO SCHOOL. THE PHYSICIAN MAY ALSO FAX TO ABOVE NUMBER.

EMERGENCY CONTACT NUMBERS

1.________________	PHONE: ________________	2. ________________	PHONE: ________________
(NAME)	(HOME, WORK, CELL)	(NAME)	(HOME, WORK, CELL)

From: Kirstie Stivers, RN, BSN
Nurse Coordinator, Madison Consolidated Schools

To: The parent or guardian of: ____

Dear Parent,

The following are the requirements for your child regarding his/her seizure disorder. These are the things that must be in place for your child:

- ➢ Physicians authorization and Plan of Care (form on reverse side)
- ➢ Any medication necessary for your child
- ➢ Authorization to Release form - (Allows us to receive orders from MD office -form enclosed)
- ➢ Parent Permission for any medications given at school (form enclosed)

All these things are necessary for the safety of your child and these rules must be adhered to. We will make no exceptions. If you have any questions or concerns, please feel free to contact me. We look forward to having your child and want their school experiences to be positive. We will do whatever it takes to assist with any transitions necessary to accommodate your child with his/her health concern. Thank you for your cooperation.

Parent/guardian (Print) ____

I, parent/guardian of above named student, give permission for Madison Consolidated Schools Staff to administer medication and treatment as ordered above.

Parent/Guardian (Signature) _______________________________________

Date: __________________ School: ________________ Grade: ____________

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Nurse Coordinator, Madison Consolidated Schools

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