SEIZURE ASSESSMENT and CARE PLAN

For School Year: ______/______ **School___________________________**

STUDENT:________________________________ Birthdate:______________Grade:_______

PARENT/GUARDIAN NAME:_________________________________PHONE:_________________

ADDRESS:____

WORK PHONE:______________________________CELL PHONE:___________________________

PARENT/GUARDIAN NAME:_________________________________PHONE:_________________

ADDRESS:____

WORK PHONE:______________________________CELL PHONE:___________________________

In the event we are unable to reach you:
EMERGENCY PHONE CONTACT ____
(other than parent) **Name** **Relationship** **Phone**

At what age did your child have his/her first seizure?_______________________________________

Date of last seizure?____

Describe the type of seizure?____

Is your child currently on medication(s) for seizures? Yes_________ No__________
If, yes, Daily Medication Taken at Home:

Name **Dosage** **Time**

1.____

2.____

3.____

If no, has he/she *ever* been on medication for seizures? Yes__________ No___________
Prior Medication
Name **Dosage** **Age given** **Length of time**
1.____

2.____

3.____

List any physical restrictions or limitations your child may have due to seizures______________________________

____

____

please complete both pages

SEIZURE EMERGENCY PLAN Name________________________________

Please check all that apply for a step by step emergency plan in the event your child has a seizure at school:

Action for Non-Nursing Personnel

_____ Call the health office (if no answer call main office) and report location and notify that student is having a seizure.

_____ Note time seizure activity began. Monitor and record seizure activity and length of time.

_____ Protect student from injury during seizure.

_____ Assist student to the floor and put something soft under their head.

_____ Do not put anything in the student's mouth.

_____ Stay with student until the nurse or health aide arrives. If there are other students in the classroom, they should wait in the hall.

Action for Health Office Staff

_____ Will administer medication as prescribed by physician.

List medication____

_____ Will asses student and call paramedics if difficulty breathing or seizure lasts more than 5 minutes.

_____ Will initiate CPR if indicated.

Other (be specific)

____

____

____

____

When was last physician visit?____

Child's diagnosis____

Seizure type____

Name of physician treating your child for seizures:_______________________________________

____

address phone fax

____

Physician's signature **Date**

Physician comments:____

____

____

____

May the school nurse contact the physician in case there are any questions or concerns in making an emergency plan for your child? Yes____________ **No**____________

____

Parent/Guardian Signature **Date**

Received/Reviewed by:____**Date**__________________

School nurse

3.2011

LAKE ZURICH COMMUNITY UNIT
School District 95

School Medication Authorization Form

To be completed by the student's parent/guardian AND PHYSICIAN and kept in the school nurse's office or, in the absence of a school nurse, the building principal's office.

Student's Name:		Birth Date:
Address:		
Home Phone:	Emergency Phone:	
School:	Grade:	Teacher:

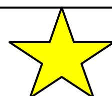
TO BE COMPLETED BY THE STUDENT'S PHYSICIAN: **(for all medication except asthma inhalers)**

Physician's printed name:		
Office Address:	Office Phone: Office Fax:	
Medication:		
Dosage:	Frequency:	
Time medication is to be administered or under what circumstances:		
Diagnosis requiring medication:		
Intended effect of this medication:		
Must this medication be administered during the school day in order to allow the student to attend school or to address the student's medical condition?		❑ ***Yes*** ❑ No
Expected side effects if any:		
Time interval for re-evaluation:		
Has student been taught to self administer this medication?		❑ Yes ❑ No
Does student have your approval to administer this medication?		❑ Yes ❑ No
Other medication student is receiving:		

Physician's Signature

Date

FOR ASTHMA INHALERS ONLY, AFFIX PRESCRIPTION LABEL HERE:

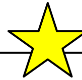
COMPLETE BOTH SIDES  PARENT SIGNATUR REQUIRED

LAKE ZURICH COMMUNITY UNIT
School District 95

By signing below, I agree:

1. That I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District 95 and itsemployees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of District 95), lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices, and

2. To indemnify and hold harmless District 95 and its employees and agents any claims, except a claim based on willful and wanton conduct arising out of the self-administration of medication by the student.



____ ____

Parent/Guardian printed name Parent/Guardian signature

FOR PARENTS OF STUDENTS WHO SELF ADMINISTER MEDICATIONS

I authorize the School District 95 and its employees and agents, to allow my child or ward to possess and use his or her asthma medication, diabetic supplies or “Epi-Pen” (1) while in school, (2) while at a school sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property.
I verify that my child has been instructed and can self administer his/her prescribed medication in accordance with the prescribed dosage and route. Also my child is aware of potential side effects, when medication is not effective, and when additional help is needed. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student’s self-administration of medication (105 ILCS 5/22-30).

If you agree, please initial:____

Parent/Guardian initial

1-18-11

COMPLETE BOTH SIDES