## Mecklenburg County Health Department School Health Program

_		Year:	Grade:	Date of Birth:	Allergies:
Homeroom	Teacher:		Roor	n: Student I	D #:
Parent/Gua	rdian:			Ph. (H):	
Address:				Ph. (W):	
Parent/Gua	rdian:			Ph. (H):	
Address:				Ph. (W):	
Emergency	Phone Contact #1:				
	Name			Relationship	Phone
Emergency	Phone Contact #2:				
<b>3</b> 1	Name	1. 1		Relationship	Phone
referred H	lospital:				
<b>EMER</b>	GENCY PLAN	(Fill in bl	lanks, cross out and i	nitial any steps not needed for	r this student.)
				• •	
2mergeno	cy action is necessar	y when the stu	agent has the fo	nowing symptoms:	
-	take during a seizu Stay with student during seizure epi	during and aft	er seizure. Note	e duration of seizure a	nd type of body movement
2.	Assist to lying posaround neck.		f consciousness	occurs. Remove glass	ses if wearing, loosen clothin
<ul><li>2.</li><li>3.</li></ul>	around neck.	sition if loss of		occurs. Remove glass	ses if wearing, loosen clothin
	around neck.  Turn on side as so	sition if loss of	».	occurs. Remove glass	
3. 4.	around neck.  Turn on side as so  Clear area around	sition if loss of on as possible child to preve	e. ent injury; remov	· ·	area if possible.
3. 4.	around neck.  Turn on side as so  Clear area around  DO NOT RESTE	sition if loss of on as possible child to preve	e. ent injury; remov	ve other students from  ACE ANYTHING IN	area if possible.
3. 4. 5.	around neck.  Turn on side as so Clear area around  DO NOT RESTE  Monitor breathing  Call 911 if seizure waking or there ar	sition if loss of on as possible child to preve RAIN MOVE and begin articles lasts longer the re signs of sign	ent injury; remove the second	we other students from  ACE ANYTHING IN  on if breathing does nothe student has one sein	area if possible.  N MOUTH.  t resume spontaneously.  zure after another without distress. If 911 is called,
3. 4. 5.	around neck.  Turn on side as so Clear area around  DO NOT RESTE  Monitor breathing  Call 911 if seizure waking or there ar transport to	sition if loss of on as possible child to preve RAIN MOVEL and begin arti- e lasts longer the re signs of sign	ent injury; remove the second	ve other students from  ACE ANYTHING IN  on if breathing does not  the student has one seint physical/respiratory of	area if possible.  N MOUTH.  t resume spontaneously.  zure after another without distress. If 911 is called, Hospital.
3. 4. 5. 6. 7.	around neck.  Turn on side as so Clear area around  DO NOT RESTE  Monitor breathing  Call 911 if seizure waking or there ar transport to	sition if loss of on as possible child to preve RAIN MOVE and begin art e lasts longer the re signs of sign	ent injury; remove the second	we other students from  ACE ANYTHING IN  In if breathing does not the student has one seint physical/respiratory of	area if possible.  N MOUTH.  t resume spontaneously.  zure after another without distress. If 911 is called, Hospital.
3. 4. 5. 6. 7.	around neck.  Turn on side as so Clear area around  DO NOT RESTE  Monitor breathing  Call 911 if seizure waking or there are transport to  When seizure is o  Notify school nurs	sition if loss of on as possible child to preve RAIN MOVE and begin arti- e lasts longer the re signs of sign ver, allow chillse.	ent injury; remove the ment of the ment of the minutes, the minutes of the minutes of the ment of the	we other students from  ACE ANYTHING IN  In if breathing does not the student has one seint physical/respiratory of	area if possible.  N MOUTH.  t resume spontaneously.  zure after another without distress. If 911 is called, Hospital.  rdian.

## **Daily Seizure Management Plan:**

1.	What type of seizures does your child have and how often do they occur?					
	Date of last seizure:					
2.	Describe your child's symptoms during and after a seizure episode.					
3.	Does your child have an aura or warning of a seizure coming? Yes No					
	Is he/she able to notify anyone that a seizure is coming? Yes No					
4.	Name medications taken routinely. How often and how much?					
	At home:					
	At school:					
	Does your child experience any side effects to these medications? Please list:					
	Are there any sports/activities in which your child CANNOT participate?					
	NOTE: If medications are to be taken at school, a Medication Authorization form must be completed by at and physician and kept at the school.					
Parent/Gu	ardian Signature: Date:					
School Nu	rrse Signature: Date:					

This information will be shared with appropriate school staff unless you state otherwise.

7/09 lp CI 19