Avon Lake City Schools
175 Avon Belden Road
Avon Lake, Ohio 44012

Seizure Health Care Plan

Student's Name: _____School Year: _____

DOB: _____ Teacher: _____ Grade: _____

Typical Seizure Pattern: Including Warning Signs (Aura): Appearance of Seizure Activity.

During a Seizure:

Administer the following emergency medication if the seizure lasts longer than _____minutes (include dose and route):_____

After a Seizure:

CALL 911 FOR:

A seizure lasting longer than _____ minutes

Any signs of respiratory distress (stops breathing or turns dusky/blue)

Other: _____
_____

Other health concerns:	
Medications:	**Dose/Time (AM-PM):**
Dietary concerns/restrictions:	

Emergency Contacts:

Parent/Guardians:
1. Name: _____

Home _____ Work _____ Cell _____

2. Name: _____

Home _____ Work _____ Cell _____

Other Emergency Contact if parent/guardian is unavailable:
Name _____ Relationship _____

Home _____ Work _____ Cell _____

Primary Care Provider: _____ **Telephone#** _____
Neurologist: _____ **Telephone#** _____

Physician Signature: _____ **Date:** _____
Parent Signature: _____ **Date:** _____
Nurse Signature: _____ **Date:** _____

I, _____ authorize the school's nurse to contact my child's health care provider to clarify facts surrounding my child's medical condition or treatment plan. This information will only be shared with staff members with legitimate educational interests and only when necessary.

Parent Signature _____ Date _____